RFS #10-40
ATTACHMENT D
CONTRACTOR SCOPE OF WORK

Table of Contents

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This Scope of Work is part of a Request for Services (RFS) to provide risk-based managed care services to Medicaid beneficiaries enrolled in the State of Indiana's Hoosier Healthwise and Healthy Indiana Plan (HIP) programs. The State is looking to contract on a statewide basis with managed care organizations (MCOs) with a demonstrated capacity to actively manage care for a low income population.

Because Hoosier Healthwise and HIP are financed in part by federal Medicaid funds, Contractors must meet all applicable requirements of Medicaid managed care organizations under Section 1903(m) and 1932 of the Social Security Act, as well as the implementing regulations set forth in 42 CFR 438. Contractors must also ensure that its network providers, including out-of-state providers, enroll in the Indiana Health Coverage Programs (IHCP) before they begin providing health care services to members. Further information about IHCP provider enrollment is located at:

http://www.indianamedicaid.com/ihcp/ProviderServices/enrollment_provider.asp

Unless otherwise indicated, the requirements set forth in this Scope of Work apply to the Contractor's responsibilities under both the Hoosier Healthwise and HIP programs.

1.0 Background

The Office of Medicaid Policy and Planning (OMPP) of the Indiana Family and Social Services Administration (FSSA) manages the Hoosier Healthwise and HIP programs. Hoosier Healthwise and HIP are Medicaid programs that help 680,000 Hoosiers.[1] Together, these programs aim to provide comprehensive health care coverage for Hoosier families.

Brief descriptions of the Hoosier Healthwise and HIP programs are outlined below. Both programs seek not only to provide health coverage to an uninsured population, but to improve health, promote prevention and encourage healthy lifestyles. While the Hoosier Healthwise and HIP programs have similarities, they serve different populations. Prior to the release of the RFS, the State has been operating the two programs separately. The purpose of this RFS is to integrate the two programs to the greatest extent possible, thus creating a "family health plan" that results in a seamless experience for Hoosier families. To this end, the State will contract with the same MCOs to manage both programs.

The State is particularly interested in contracting with MCOs that can not only perform the administrative functions of a typical insurer, but that is adept at addressing the unique challenges of low income populations and can manage and integrate care along the continuum of health care services. Goals for both programs include:

- **Improve health outcomes**
- Promote primary and preventive care
- Foster personal responsibility and healthy lifestyles
- **Assure the appropriate use of health care services**
- Develop informed health care consumers by increasing health literacy and providing price and quality transparency
- Improve access to health care services
- Encourage quality, continuity and appropriateness of medical care

[1] The enrollment figures provided in this Scope of Work are current figures only. Enrollment in the Hoosier Healthwise and HIP programs may increase or decrease in the future based upon federal policies, program priorities, available funding, etc.

- Deliver coverage cost-effectively
- Identify high risk members and provide effective disease management, case management and care management programs for those that would benefit from such services
- Coordinate health and social services
- Integrate physical and behavioral health services
- Develop innovative member and provider incentives
- Use technology to ease administrative burden and help accomplish program goals
- Develop innovative utilization management techniques that incorporate member and provider education to facilitate the right care, at the right time, in the right location
- Emphasize communication and collaboration with network providers
- Engage in provider and member outreach regarding preventive care, wellness and a holistic approach

1.1 Hoosier Healthwise

Hoosier Healthwise is a risk-based managed care program created to cover children, pregnant women and low-income working families. Indiana offers Hoosier Healthwise members comprehensive benefits in four benefit packages (Package A, B, C or P) depending on the member's category of aid. A description of the Hoosier Healthwise covered services in each benefit package is set forth in Attachment E of the RFS.

The Hoosier Healthwise program currently serves over 630,000 members.

1.2 Healthy Indiana Plan (HIP)

The Healthy Indiana Plan (HIP) is a program created to provide health care coverage to low-income, uninsured adults without access to employer sponsored health insurance. Indiana offers HIP members a comprehensive benefit package through a deductible health plan paired with a personal health care account called a POWER (Personal Wellness and Responsibility) Account. The health plan is subject to an $1,100 deductible and includes at least $500 of "first dollar" coverage for preventive services. The $500 preventive services benefit is designed to help eliminate barriers to obtaining preventive care. The health plan is also subject to a $300,000 annual benefit cap and a $1,000,000 lifetime benefit cap. A description of the HIP covered services is set forth in Attachment E of the RFS.

The POWER Account is modeled in the spirit of a traditional Health Savings Account (HSA) and is funded with state and individual contributions. Employers may also contribute with some restrictions. Members use POWER Account funds to meet the $1,100 deductible. POWER Accounts are funded with post-tax dollars and are not considered HSAs or other health spending accounts (e.g., Flexible Spending Accounts, Health Reimbursement Accounts, etc.) under federal law. Therefore, they are not subject to regulation under the U.S. Tax Code as such.

With a few exceptions, HIP members are guaranteed eligible for a twelve (12)-month benefit period so long as they continue making their required POWER Account contributions. Individual contributions are based on a sliding scale.

Approximately 47,000 members are currently enrolled in HIP. Unlike Hoosier Healthwise, HIP is not an entitlement program. Enrollment may be capped based on availability of state and federal funds. Certain high-risk individuals, as defined by OMPP, are assigned to the Enhanced Services Plan (ESP) instead of an MCO. The ESP is administered by the Indiana Comprehensive Health Insurance Association (ICHIA) and is outside the scope of this RFS.

2.0 Administrative Requirements

2.1 State Licensure

Prior to the Contract effective date, and as verified in the readiness review, the Contractor must be:

- An Indiana-licensed accident or sickness insurer; or
- An Indiana-licensed health maintenance organization (HMO).

2.2 National Committee for Quality Assurance (NCQA) Accreditation

As required by IC 12-15-12-21, if the Contractor was a Hoosier Healthwise vendor before July 1, 2008, the Contractor must be accredited by the National Committee for Quality Assurance (NCQA) on or before the Contract start date.

If the Contractor was not a Hoosier Healthwise vendor before July 1, 2008, the Contractor must initiate the NCQA health plan accreditation process immediately following the Contract start date. The Contractor must achieve accreditation prior to December 31, 2012, unless the Contractor requests an extension and an extension is granted by OMPP.

2.3 Indiana Check-Up Plan Buy-in Product

The Contractor shall make available for purchase Indiana Check-Up Plan Buy-In Products as set forth in this section.

Pursuant to IC 12-15-44 and 405 IAC 9-8-3, a Contractor or an affiliate of a Contractor that offers HIP coverage under this RFS must also make the same health care coverage available for purchase by an individual who:

- Although eligible for state-subsidized coverage under HIP (i.e., has income under 200% of the FPL and meets other eligibility requirements), is unable to enroll in HIP at the time of application because the annual state appropriation for HIP has been exhausted and the State has temporarily stopped accepting new members into HIP (see IC 12-15-44-15);
- Has not had health insurance coverage for the previous six (6) months;
- Is not eligible for health insurance coverage through his or her employer; and
- Has not declined health insurance coverage during his or her employer's last open enrollment period.

This coverage for individuals eligible for HIP but unable to participate due to an enrollment cap is referred to as the "Tier Two" Indiana Check Up Plan Buy-In Product. In offering the Tier Two Indiana Check Up Plan Buy-In Product to individuals eligible for, but unable to enroll in, HIP, the

Contractor must charge individuals in the same age and sex category the same capitation rates paid to the Contractor by the State under the Contract. See IC 12-15-44-15. However, in the case of the non-caretaker population, where the State's payments to the Contractor are not limited to capitation payments only, the State will provide a separate rate schedule. The Contractor must charge the non-caretaker population according to this separate rate schedule provided by the State.

The Contractor or an affiliate of the Contractor is also required to make the Indiana Check Up Plan Buy-In Product available for purchase by all other individuals not eligible for HIP (i.e., individuals with incomes above 200% of the FPL), so long as the individual has not had health insurance coverage during the previous six (6) months. This coverage is referred to as the "Tier Three" Indiana Check Up Plan Buy-In Product. In offering the Tier Three Indiana Check Up Plan Buy-In Product to individuals with incomes above 200% of the FPL, the Contractor may apply its standard individual or small group insurance underwriting and rating practices.

The State will provide no funding to the Contractor for offering the groups identified in this section an opportunity to purchase the Indiana Check Up Plan Buy-In Products.

If the Contractor offers the Indiana Check Up Plan Buy-In Products through an affiliate, the Contractor will be required to enter into a subcontract with the affiliate. The subcontract will be subject to the subcontracting requirements set forth in Section 2.8, and the affiliate will be bound by the same requirements the Contractor would be bound by had the Contractor provided its Indiana Check Up Plan Buy-In Products for purchase directly and not through the affiliate.

2.4 Administrative and Organizational Structure

The Contractor must maintain an administrative and organizational structure that supports effective and efficient delivery of integrated services to all members in a family. The organizational structure must demonstrate a coordinated approach to managing the delivery of health care services to its Hoosier Healthwise and HIP populations. The Contractor's organizational structure must support collection and integration of data from every aspect of its delivery system and its internal functional units to accurately report the Contractor's performance. The Contractor must also have policies and procedures in place that support the integration of financial and performance data and comply with all applicable federal and state requirements.

Prior to the Contract effective date, OMPP will provide a series of orientation sessions to assist the Contractor in developing its internal operations to support the requirements of the Contract (i.e., data submission, data transmissions, reporting formats, etc.).

The Contractor must have in place sufficient administrative and clinical staff and organizational components to comply with all Hoosier Healthwise and HIP program requirements and standards. The Contractor must manage the functional linkage of the following major operational areas:

- Administrative and fiscal management
- Member services
- Provider services
- Marketing
- Provider enrollment
- Network development and management

- Quality management and improvement
- Utilization and care management
- Behavioral and physical health
- POWER Account administration (HIP only)
- POWER Account contribution and Hoosier Healthwise Package C (CHIP) premium collections
- Information systems
- Performance data reporting and encounter claims submission
- Claims payments
- Grievances and appeals

2.5 Staffing

The Contractor must maintain a high level of plan performance and data reporting capabilities regardless of staff vacancies or turnover. The Contractor must have an effective method to address and minimize staff turnover (e.g., cross training, use of temporary staff or consultants, etc.) as well as processes to solicit staff feedback to improve the work environment. These processes will be verified during the readiness review.

The Contractor must have position descriptions for the positions discussed in this section that include the responsibilities and qualifications of the position such as, but not limited to: education (e.g., high school, college degree or graduate degree), professional credentials (e.g., licensure or certifications), work experience, membership in professional or community associations, etc.

2.5.1 Key Staff

The Contractor must employ the key staff members listed below. The State encourages the Contractor to have the same key staff member dedicated to both their Hoosier Healthwise and HIP lines of business.

The Contractor must have an office in the State of Indiana from which, at a minimum, key staff members physically perform the majority of their daily duties and responsibilities, and a major portion of the Contractor's operations take place. For all functions conducted outside of the State of Indiana, the Contractor must ensure a seamless integration of its operations. The Contractor shall be responsible for ensuring all staff functions conducted outside of the State of Indiana are readily reportable to OMPP at all times. Indiana-based staff shall maintain a full understanding of the operations conducted outside of the State of Indiana, and must be prepared to discuss these operations with OMPP upon request, including during unannounced OMPP site visits.

The Contractor must provide written notification to OMPP of anticipated vacancies of key staff within five (5) business days of receiving the key staff person's notice to terminate employment or five (5) business days before the vacancy occurs, whichever occurs first. At that time, the Contractor must present OMPP with an interim plan to cover the responsibilities created by the key staff vacancy. Likewise, the Contractor must notify OMPP in writing within five (5) business days after a candidate's acceptance to fill a key staff position or five (5) business days prior to the candidate's start date, whichever occurs first.

RFS #10-40
ATTACHMENT D
CONTRACTOR SCOPE OF WORK

In addition to attendance at vendor meetings, all key staff must be accessible to OMPP and its other program subcontractors via voicemail and electronic mail systems. As part of its annual and quarterly reporting, the Contractor must submit to OMPP an updated organizational chart including e-mail addresses and phone numbers for key staff.

OMPP reserves the right to approve or deny the individuals filling the key staff positions set forth below.

The key staff positions include, but are not limited to:

- **Chief Executive Officer –** The Chief Executive Officer or Executive Director has full and final responsibility for plan management and compliance with all provisions of the Contract.

- **Chief Financial Officer** – The Chief Financial Officer must oversee the budget and accounting systems of the Contractor for the Hoosier Healthwise and HIP programs. This Officer must, at a minimum, be responsible for ensuring that the Contractor meets the State's requirements for financial performance and reporting.

- **Compliance Officer** – The Contractor must employ a Compliance Officer who is accountable to the Contractor's executive leadership and dedicated full-time to the Hoosier Healthwise and HIP programs. This individual will be the primary liaison with the State (or its designees) to facilitate communications between OMPP, the State's contractors and the Contractor's executive leadership and staff. This individual must maintain a current knowledge of federal and state legislation, legislative initiatives and regulations that may impact the Hoosier Healthwise and HIP programs. It is the responsibility of the Compliance Officer to coordinate reporting to the State as defined in Section 10 and to review the timeliness, accuracy and completeness of reports and data submissions to the State. The Compliance Officer, in close coordination with other key staff, has primary responsibility for ensuring all Contractor functions are in compliance with the terms of the Contract. The Compliance Officer shall meet with the OMPP Surveillance and Utilization Review Unit (SUR) on a quarterly basis.

- **Information Systems (IS) Coordinator** – The Contractor must employ an IS Coordinator who is dedicated full-time to the Hoosier Healthwise and HIP programs. This individual will oversee the Contractor's Hoosier Healthwise and HIP information system(s) and serve as a liaison between the Contractor and the State fiscal agent or other OMPP contractors regarding encounter claims submissions, capitation payment, member eligibility, POWER Account administration (HIP only), enrollment and other data transmission interface and management issues. The IS Coordinator, in close coordination with other key staff, is responsible for ensuring all program data transactions are in compliance with the terms of the Contract. The IS Coordinator is responsible for attendance at all Technical Meetings called by the State. If the IS Coordinator is unable to attend a Technical Meeting, the IS Coordinator shall designate a representative to take his or her place. This representative must report back to the IS Coordinator on the Technical Meeting's agenda and action items. For more information on the IS program requirements, see Section 9.

- **Medical Director** – The Contractor must employ the services of a Medical Director who is an Indiana-licensed IHCP provider board certified in family medicine. If the Medical Director is not board certified in family medicine, they must be supported by a clinical team with experience in pediatrics, behavioral health, adult medicine and obstetrics/gynecology. The Medical Director must be dedicated full-time to the Hoosier Healthwise and HIP programs. The Medical Director must oversee the development and implementation of the Contractor's disease management, case management and care management programs; oversee the development of the Contractor's clinical practice guidelines; review any potential quality of care problems; oversee the Contractor's clinical management program and programs that address special needs populations; oversee health screenings; serve as the Contractor's medical professional interface with the Contractor's primary medical providers (PMPs) and specialty providers; and direct the Quality Management and Utilization Management programs, including, but not limited to, monitoring, corrective actions and other quality management, utilization management or program integrity activities. The Medical Director, in close coordination with other key staff, is responsible for ensuring that the medical management and quality management components of the Contractor's operations are in compliance with the terms of the Contract. The Medical Director shall comply with the pharmacy-related responsibilities set forth in Section 5.4. The Medical Director shall attend all OMPP quality meetings, including the Quality Strategy Committee meetings. If the Medical Director is unable to attend an OMPP quality meeting, the Medical Director shall designate a representative to take his or her place. This representative must report back to the Medical Director on the meeting's agenda and action items.

- **Member Services Manager** – The Contractor must employ a Member Services Manager who is dedicated full-time to Hoosier Healthwise and HIP member services, which must be available via the member helpline and the member website, including through a member portal. The Member Services Manager must, at a minimum, be responsible for directing the activities of the Contractor's member services, including, but not limited to, member helpline telephone performance, member e-mail communications, member education, the member website, member outreach programs, development, approval and distribution of member materials and employer outreach for HIP members. The Member Services Manager manages the member grievances and appeals process, and works closely with other managers (especially, the Quality Manager, Utilization Manager and Medical Director) and departments to address and resolve member grievances and appeals. The Member Services Manager must oversee the interface with the Enrollment Broker regarding such issues as member enrollment and disenrollment, member PMP assignments and changes, member eligibility and newborn enrollment activities (Hoosier Healthwise only). The Member Services Manager must provide an orientation and on-going training for member services helpline representatives, at a minimum, to support accurately informing members of how the Contractor operates, availability of covered services, benefit limitations, health screenings, emergency services, PMP assignment and changes, specialty provider referrals, self-referral services, preventive and enhanced services, POWER Account services (HIP only), well-child services (Hoosier Healthwise only) and member grievances and appeals procedures. The Member Services Manager, in close coordination with other key staff, is responsible for ensuring that all of the Contractor's member services operations are in compliance with the terms of the Contract. For more information regarding the member services program requirements, see Section 6.

- **Provider Services Manager** – The Contractor must employ a Provider Services Manager who is dedicated full-time to the Hoosier Healthwise and HIP programs. The Provider Services Manager must, at a minimum, be responsible for the provider services helpline performance, provider recruitment, contracting and credentialing, facilitating the provider claims dispute process, developing and distributing the provider manual and education materials and developing outreach programs. The Provider Services Manager oversees the process of providing information to the State fiscal agent regarding the Contractor's provider network, including PMPs, via WebInterchange. The Provider Services Manager, in close coordination with other key staff, is responsible for ensuring that all of the Contractor's provider services operations are in compliance with the terms of the Contract. For more information regarding the provider services program requirements, see Section 7.

- **Quality Management Manager** – The Contractor must employ a Quality Management Manager who is dedicated full-time to the Hoosier Healthwise and HIP programs. The Quality Management Manager must, at a minimum, be responsible for directing the activities of the Contractor's quality management staff in monitoring and auditing the Contractor's health care delivery system, including, but not limited to, internal processes and procedures, provider network(s), service quality and clinical quality. The Quality Management Manager must assist the Contractor's Compliance Officer in overseeing the activities of the Contractor's operations to meet the State's goal of providing health care services that improve the health status and health outcomes of Hoosier Healthwise and HIP members. For more information regarding the quality management requirements, see Section 8.

- **Utilization Management Manager** – The Contractor must employ a Utilization Management Manager who is dedicated full-time to the Hoosier Healthwise and HIP programs. The Utilization Management Manager must, at a minimum, be responsible for directing the activities of the utilization management staff. With direct supervision by the Medical Director, the Utilization Management Manager must direct staff performance regarding prior authorization, medical necessity determinations, concurrent review, retrospective review, appropriate utilization of health care services, continuity of care, care coordination and other clinical and medical management programs. For more information regarding the utilization management requirements, see Section 8.

- **Behavioral Health Manager –** The Contractor must employ a Behavioral Health Manager who is dedicated full-time to the Hoosier Healthwise and HIP programs. The Behavioral Health Manager is responsible for ensuring that the Contractor's behavioral health operations, which include the operations of any behavioral health subcontractors, are in compliance with the terms of the Contract. The Behavioral Health Manager must coordinate with all functional areas, including quality management, utilization management, network development and management, provider relations, member outreach and education, member services, contract compliance and reporting. The Behavioral Health Manager must fully participate in all quality management and improvement activities, including participating in Quality Strategy Committee meetings and in the Mental Health Quality Assurance Committee. The Behavioral Health Manager must work closely with the Contractor's network development and provider relations staff to develop and maintain the behavioral health network and ensure that it is fully

integrated with the physical health provider network. The Behavioral Health Manager shall collaborate with key staff to ensure the coordination of physical and behavioral health care as set forth in Section 5.7. The Behavioral Health Manager must work closely with the utilization management staff to monitor behavioral health utilization, especially to identify and address potential behavioral health under- or over-utilization. The Behavioral Health Manager or designee shall be the primary liaison with behavioral health community resources, including Community Mental Health Centers (CMHCs), and be responsible for all reporting related to the Contractor's provision of behavioral health services.

If the Contractor subcontracts with a behavioral health organization (BHO) to provide behavioral health services, the Behavioral Health Manager will continue to work closely with the Contractor's other managers to provide monitoring and oversight of the BHO and to ensure the BHO's compliance with the Contract. (See Section 2.8 regarding requirements for OMPP's approval of subcontractors.)

- **Data Compliance Manager.** The Contractor must employ a Data Compliance Manager who is dedicated full-time to the Hoosier Healthwise and HIP programs. The Data Compliance Manager will provide oversight to ensure the Contractor's Hoosier Healthwise and HIP data conform to FSSA and OMPP data standards and policies. The Data Compliance Manager must have extensive experience in managing data quality and data exchange processes, including data integration and data verification. The Data Compliance Manager must also be knowledgeable in health care data and health care data exchange standards. The Data Compliance Manager will manage data quality, change management and data exchanges with OMPP. The Data Compliance Manager shall be responsible for data quality and verification, data delivery, change management processes used for data extract corrections and modification and enforcement of data standards and policies for data exchanges to OMPP as defined by the FSSA Data Architect. The Data Compliance Manager shall coordinate with the FSSA Data Architect to implement data exchange requirements.

- **CHIP Premium/POWER Account Operations Manager.** The Contractor must employ a CHIP Premium/POWER Account Operations Manager who is dedicated full-time to the HIP program's POWER Account operations and the Hoosier Healthwise Package C (CHIP) program's premium collections. The CHIP Premium/POWER Account Operations Manager shall be responsible for overseeing the accurate and efficient administration of member POWER Accounts, as outlined in the Managed Care Policies and Procedures Manual, including but not limited to: POWER Account contribution billing, reminders and collections; applying member, state and employer contributions; termination for non-payment; Power Account Reconciliation files (PRFs); POWER Account statements; POWER Account reconciliation and rollover; POWER Account contribution recalculations; POWER Account transfers; and POWER Account reporting. The POWER Account Operations Manager shall also oversee the Hoosier Healthwise Package C (CHIP) premium collection process, including invoicing, reminders and termination for non-payment.

2.5.2 Staff Positions

In addition to the required key staff described in Section 2.5.1, the Contractor must employ those additional staff necessary to ensure the Contractor's compliance with the State's performance requirements. Suggested staff may include but are not limited to:

- A **Grievance coordinator** to investigate and coordinate responses to address member and provider grievances and appeals against the Contractor and interface with the FSSA Hearings Office.

- **Technical support services staff** to ensure the timely and efficient maintenance of information technology support services, production of reports and processing of data requests and submission of encounter data.

- **Quality management staff** dedicated to perform quality management and improvement activities, and participate in the Contractor's internal Quality Management and Improvement Committee.

- **Utilization and medical management** staff dedicated to perform utilization management and review activities.

- **Case managers** who provide case management, care management, care coordination and utilization management for high-risk or high-cost members receiving physical health and/or behavioral health services. The case managers must identify the needs and risks of the Contractor's membership, including social barriers; serve as a coordinator to link members to services; and ensure that members receive the appropriate care in the appropriate setting by the appropriate providers.

- **Member services representatives** to coordinate communications between the Contractor and its members; respond to member inquiries; and assist all members regarding issues such as the Contractor's policies, procedures, general operations, benefit coverage and eligibility. Member services staff should have access to real time data on members, including eligibility status, POWER Account contributions and transactions, Hoosier Healthwise Package C (CHIP) premium payments, PMP assignments and all service and utilization data. Member services staff must have the appropriate training and demonstrate full competency before interacting with members.

- **Member marketing and outreach staff** to manage joint marketing and outreach efforts for the Hoosier Healthwise and HIP programs, paying particular attention to eligible HIP parents and caretaker relatives.

- **Compliance staff** to support the Compliance Officer and help ensure all Contractor functions are in compliance with state and federal laws and regulations, the State's policies and procedures and the terms of the Contract.

- **Provider representatives** to develop the Contractor's network and coordinate communications between the Contractor and contracted and non-contracted providers.

- **Claims processors** to process electronic and paper claims in a timely and accurate manner, process claims correction letters, process claims resubmissions and address overall disposition of all claims for the Contractor, per state and federal guidelines, as well as a sufficient number of staff to ensure the submission of timely, complete and accurate encounter claims data.

- **Member and provider education/outreach staff** to promote health-related prevention and wellness education and programs; maintain member and provider awareness of the Contractor's policies and procedures; and identify and address barriers to an effective health care delivery system for the Contractor's members and providers.

- **Website staff** to maintain and update the Contractor's member and provider websites and member portal.

- **POWER Account and CHIP premium collection staff** to support the Contractor's HIP POWER Account operations and POWER Account contribution and Hoosier Healthwise Package C (CHIP) premium billing and collections.

2.5.3 Training

On an ongoing basis, the Contractor must ensure that each staff person, including subcontractors' staff, has appropriate education and experience to fulfill the requirements of their position, as well as ongoing training (e.g., orientation, cultural sensitivity, program updates, clinical protocols, policies and procedures compliance, management information systems, training on fraud and abuse and the False Claims Act, etc.). The Contractor must ensure that all staff are trained in the major components of the Hoosier Healthwise and HIP programs. The following staff must receive additional training:

- **Utilization management staff** must receive ongoing training regarding interpretation and application of the Contractor's utilization management guidelines. The ongoing training must, at minimum, be conducted on a quarterly basis and as changes to the Contractor's utilization management guidelines and policies and procedures occur.

- **Staff members with POWER Account responsibilities** must receive detailed POWER Account education and training on topics including but not limited to: billing and collections, POWER Account contribution recalculations, POWER Account rollover, POWER Account termination and the POWER Account Reconciliation File (PRF), 820 and 834 transactions.

The Contractor must update its training materials on a regular basis to reflect program changes. The Contractor must maintain documentation to confirm its internal staff training, curricula, schedules and attendance, and must provide this information to OMPP upon request and during regular on-site visits. For its utilization management and POWER Account training activities in particular, the Contractor must be prepared to provide a written training plan, which shall include dates and subject matter, as well as training materials, upon request by OMPP.

2.5.4 Debarred Individuals

In accordance with 42 CFR 438.610, the Contractor must not knowingly have a relationship with the following:

- An individual who is debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549

- An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above

The relationships include directors, officers or partners of the Contractor, persons with beneficial ownership of five percent (5%) or more of the Contractor's equity, or persons with an employment, consulting or other arrangement with the Contractor for the provision of items and services that are significant and material to the Contractor's obligations under the Contract.

In accordance with 42 CFR 438.610, if OMPP finds that the Contractor is in violation of this regulation, OMPP will notify the Secretary of noncompliance and determine if the agreement will continue to exist.

2.6 OMPP Meeting Requirements

OMPP conducts meetings and collaborative workgroups for the Hoosier Healthwise and HIP programs. The Contractor must comply with all meeting requirements established by OMPP, and is expected to cooperate with OMPP and/or its contractors in preparing for and participating in these meetings. OMPP reserves the right to cancel any regularly scheduled meetings, change the meeting frequency or format or add meetings to the schedule as it deems necessary.

OMPP reserves the right to meet at least annually with the Contractor's executive leadership to review the Contractor's performance, discuss the Contractor's outstanding or commendable contributions, identify areas for improvement and outline upcoming issues that may impact the Contractor or the Hoosier Healthwise and HIP programs.

2.7 Financial Stability

The Contractor must meet and comply with all requirements located in Title 27, Articles 1 through 15, of the Indiana Code. This includes, but is not limited to, the requirements pertaining to financial solvency, reinsurance and policy contracts, as well as administration of these processes.

OMPP and the Indiana Department of Insurance (IDOI) will monitor the Contractor's financial performance. OMPP will include IDOI findings in their monitoring activities. OMPP must be copied on required filings with IDOI, and the required filings must break out financial information for the Hoosier Healthwise and HIP lines of business separately. The financial performance reporting requirements are listed in Section 10 and are further described in the Contractor Reporting Manual, which shall be provided following the Contract award date.

2.7.1 Solvency

The Contractor must maintain a fiscally solvent operation per federal regulations and IDOI's requirements for a minimum net worth and risk-based capital. The Contractor must have a process in place to review and authorize contracts established for reinsurance and third party liability, if applicable.

The Contractor must comply with the federal requirements for protection against insolvency pursuant to 42 CFR 438.116. These requirements provide that, unless the Contractor is a federally qualified HMO (as defined in Section 1310 of the Public Health Service Act), the Contractor must:

- Provide assurances satisfactory to the State showing that its provision against the risk of insolvency is adequate to ensure that its members will not be liable for the Contractor's debts if the entity becomes insolvent

- Meet the solvency standards established by the State for private health maintenance organizations, or be licensed or certified by the State as a risk-bearing entity

Also see Section 2.7.3 below.

2.7.2 Insurance

The Contractor must be in compliance with all applicable insurance laws of the State of Indiana and the federal government throughout the term of the Contract. No less than ninety (90) calendar days prior to delivering services under the Contract, the Contractor must obtain Fidelity Bond or Fidelity Insurance, as defined in IC 27-13-5-2, from an insurance company duly authorized to do business in the State of Indiana.

No less than thirty (30) calendar days before the policy renewal effective date, the Contractor must submit to OMPP its certificate of insurance for each renewal period for review and approval.

2.7.3 Reinsurance – Hoosier Healthwise

The following reinsurance requirements apply to the Contractor's Hoosier Healthwise line of business only. The Contractor must purchase reinsurance from a commercial reinsurer and must establish reinsurance agreements meeting the requirements listed below. The Contractor must submit new policies, renewals or amendments to OMPP for review and approval at least one hundred and twenty (120) calendar days before becoming effective.

- Agreements and Coverage

  - The attachment point must be equal to or less than $200,000 and shall apply to all services. The Contractor electing to establish commercial reinsurance agreements with an attachment point greater than $200,000 must provide a justification in its proposal or submit justification to OMPP in writing at least one hundred and twenty (120) calendar days prior to the policy renewal date or date of the proposed change. The Contractor must receive approval from OMPP before changing the attachment point.

- The Contractor's co-insurance responsibilities above the attachment point shall be no greater than twenty percent (20%).

- Reinsurance agreements must transfer risk from the Contractor to the reinsurer.

- The reinsurer's payment to the Contractor must depend on and vary directly with the amount and timing of claims settled under the reinsured contract. Contractual features that delay timely reimbursement are not acceptable.

- The Contractor must maintain a plan acceptable to the IDOI commissioner for continuation of benefits in the event of receivership. The Contractor must finance the greater of $1,000,000 or total projected costs as calculated by the form set forth in 760 IAC 1-70-8.

- The Contractor must obtain continuation of coverage insurance (insolvency insurance) to continue plan benefits for members until the end of the period for which premiums have been paid. This coverage must extend to members in acute care hospitals or nursing facility settings when the Contractor's insolvency occurs during the member's inpatient stay. The Contractor must continue to reimburse for its member's care under those circumstances (i.e., inpatient stays) until the member is discharged from the acute care setting or nursing facility.

- Requirements for Reinsurance Companies

  - The Contractor must submit documentation that the reinsurer follows the National Association of Insurance Commissioners' (NAIC) Reinsurance Accounting Standards.

  - The Contractor is required to obtain reinsurance from insurance organizations that have Standard and Poor's claims-paying ability ratings of "AA" or higher and a Moody's bond rating of "A1" or higher.

- Subcontractors

  - Subcontractors' reinsurance coverage requirements must be clearly defined in the reinsurance agreement.

  - Subcontractors should be encouraged to obtain their own stop-loss coverage with the above-mentioned terms.

  - If subcontractors do not obtain reinsurance on their own, the Contractor is required to forward appropriate recoveries from stop-loss coverage to applicable subcontractors.

2.7.4 Financial Accounting Requirements

The Contractor must maintain separate accounting records for the Hoosier Healthwise and HIP lines of business that incorporate performance and financial data of subcontractors, as appropriate, particularly risk-bearing subcontractors. The Contractor's accounting records must be maintained in accordance with the IDOI requirements. If the Contractor does not

provide Hoosier Healthwise- or HIP-specific information, OMPP may terminate the Contract. The Contractor must provide documentation that its accounting records are compliant with IDOI standards.

In accordance with 42 CFR 455.100-104, the Contractor must notify OMPP of any person or corporation with five percent (5%) or more of ownership or controlling interest in the Contractor and must submit financial statements for these individuals or corporations. Additionally, annual audits must include an annual actuarial opinion of the Contractor's incurred but not received claims (IBNR) specific to the Hoosier Healthwise program and the HIP program separately.

Authorized representatives or agents of the State and the federal government must have access to the Contractor's accounting records and the accounting records of its subcontractors upon reasonable notice and at reasonable times during the performance and/or retention period of the Contract for purposes of review, analysis, inspection, audit and/or reproduction. In addition, the Contractor must file with the State Insurance Commissioner the financial and other information required by the IDOI.

Copies of any accounting records pertaining to the Contract must be made available by the Contractor within ten (10) calendar days of receiving a written request from the State for specified records. If such original documentation is not made available as requested, the Contractor must provide transportation, lodging and subsistence at no cost, for all state and/or federal representatives to carry out their audit functions at the principal offices of the Contractor or other locations of such records. FSSA, IDOI, OMPP and other state and federal agencies and their respective authorized representatives or agents must have access to all accounting and financial records of any individual, partnership, firm or corporation insofar as they relate to transactions with any department, board, commission, institution or other state or federal agency connected with the Contract.

The Contractor must maintain financial records pertaining to the Contract, including all claims records, for three (3) years following the end of the federal fiscal year during which the Contract is terminated, or when all state and federal audits of the Contract have been completed, whichever is later, in accordance with 45 CFR 74.53. Financial records should address matters of ownership, organization and operation of the Contractor's financial, medical and other record keeping systems. However, accounting records pertaining to the Contract must be retained until final resolution of all pending audit questions and for one (1) year following the termination of any litigation relating to the Contract if the litigation has not terminated within the three (3)-year period.

In addition, OMPP requires Contractors to produce the following financial information, upon request:

- Tangible Net Equity (TNE) or Risk Based Capital at balance sheet date
- Cash and Cash Equivalents
- Claims payment, IBNR, reimbursement, fee for service claims, provider contracts by line of business

- Appropriate insurance coverage for medical malpractice, general liability, property, workmen's compensation and fidelity bond, in conformance with state and federal regulations

- Revenue Sufficiency by line of business /group

- Renewal Rates or Proposed Rates by line of business

- Corrective Action Plan Documentation and Implementation

- Financial, Cash Flow and Medical Expense Projections by line of business

- Underwriting Plan and Policy by line of business

- Premium Receivable Analysis by line of business

- Affiliate and Inter-company Receivables

- Current Liability Payables by line of business

- Medical Liabilities by line of business

- Copies of any correspondence to and from the IDOI

2.7.5 Reporting Transactions with Parties of Interest

Any Contractor that is not a federally qualified HMO (as defined in Section 1310 of the Public Health Service Act) must disclose to OMPP information on certain types of transactions they have with a "party in interest," as defined in the Public Health Service Act. (See §§1903(m)(2)(A)(viii) and 1903(m)(4) of the Social Security Act.) For purposes of this Scope of Work, the following reporting requirements will apply to all Contractors in the same manner that they apply to federally qualified HMOs under the Public Health Service Act.

Definition of a Party in Interest--As defined in §1318(b) of the Public Health Service Act, a party in interest is:

- Any director, officer, partner or employee responsible for management or administration of an HMO; any person who is directly or indirectly the beneficial owner of more than five percent (5%) of the equity of the HMO; any person who is the beneficial owner of a mortgage, deed of trust, note or other interest secured by, and valuing more than five percent (5%) of the HMO; and, in the case of an HMO organized as a nonprofit corporation, an incorporator or member of such corporation under applicable state corporation law;

- Any entity in which a person described in the paragraph above is director or officer; is a partner; has directly or indirectly a beneficial interest of more than five percent (5%) of the equity of the HMO; or has a mortgage, deed of trust, note or other interest valuing more than five percent (5%) of the assets of the HMO;

- Any person directly or indirectly controlling, controlled by or under common control with a HMO; and

- Any spouse, child or parent of an individual described above.

Types of Transactions Which Must Be Disclosed – Business transactions which must be disclosed include:

- Any sale, exchange or lease of any property between the HMO and a party in interest;

- Any lending of money or other extension of credit between the HMO and a party in interest; and

- Any furnishing for consideration of goods, services (including management services) or facilities between the HMO and the party in interest. This does not include salaries paid to employees for services provided in the normal course of their employment.

The information which must be disclosed in the transactions between the Contractor and a party in interest listed above includes:

- The name of the party in interest for each transaction;

- A description of each transaction and the quantity or units involved;

- The accrued dollar value of each transaction during the fiscal year; and

- Justification of the reasonableness of each transaction.

In addition to the above information on business transactions, the Contractor may be required to submit a consolidated financial statement for the Contractor and the party in interest.

If the Contract is an initial contract with OMPP, but the Contractor has operated previously in commercial or Medicare markets, information on business transactions for the entire year preceding the initial contract period must be disclosed. If the Contract is being renewed or extended, the Contractor must disclose information on business transactions which occurred during the prior contract period. The business transactions which must be reported are not limited to transactions related to serving the Medicaid enrollment, that is, all of the Contractor's business transactions must be reported.

2.7.6 Medical Loss Ratio

OMPP shall calculate the Contractor's Medical Loss Ratio (MLR) on an annual basis using the Contractor's IDOI filings. A separate MLR shall be calculated for the Contractor's Hoosier Healthwise and HIP lines of business. The MLR calculations shall be exclusive of any taxes.

- The Contractor shall maintain, at minimum, a MLR of eighty-five percent (85%) for its Hoosier Healthwise line of business

- The Contractor shall maintain, at minimum, a MLR of eighty-five percent (85%) for its HIP line of business

OMPP reserves the right to recoup excess capitation paid to the Contractor in the event the Contractor's MLR, as calculated by OMPP on an annual basis, is less than eighty-five percent (85%).

2.8 Subcontracts

The term "subcontract(s)" includes contractual agreements between the Contractor and health care providers or other ancillary medical providers. Additionally, the term "subcontract(s)" includes contracts between the Contractor and another prepaid health plan, physician-hospital organization, any entity that performs delegated activities related to the Contract and any administrative entities not involved in the actual delivery of medical care.

As specified in Section 4, any entity contracted to administer or host the POWER Accounts for HIP members or to provide any point of sale infrastructure will be considered a subcontractor. Affiliates of the Contractor that offer the Indiana Check-Up Plan Buy-In Product pursuant to IC 12-15-44-15 and 16 will also be considered subcontractors.

OMPP must approve all subcontractors and any change in subcontractors or material change to subcontracting arrangements. OMPP may waive its right to review subcontracts and material changes to subcontracts. The State encourages the Contractor to subcontract with entities that are located in the State of Indiana, and will give additional points during the bidding process to Contractors that use Indiana-based subcontractors. See Section 2.7 of the RFS, "Buy Indiana," for additional detail.

According to IC 12-15-30-5, subcontracts, including provider agreements, cannot extend beyond the term of the Contract between the Contractor and the State. A reference to this provision and its requirements must be included in all provider agreements and subcontracts.

The Contractor is responsible for the performance of any obligations that may result from the RFS. Subcontractor agreements do not terminate the legal responsibility of the Contractor to the State to ensure that all activities under the Contract are carried out. The Contractor must oversee subcontractor activities and submit an annual report on its subcontractors' compliance, corrective actions and outcomes of the Contractor's monitoring activities. The Contractor will be held accountable for any functions and responsibilities that it delegates.

The Contractor shall provide that all subcontracts with other prepaid health plans, physician hospital-organizations, any other entity that performs delegated activities related to the Contract and any administrative entities not involved in the actual delivery of medical care, indemnify and hold harmless the State of Indiana, its officers and employees from all claims and suits, including court costs, attorney's fees and other expenses, brought because of injuries or damage received or sustained by any person, persons or property that is caused by an act or omission of the Contractor and/or the subcontractors. This indemnification requirement does not extend to the contractual obligations and agreements between the Contractor and health care providers or other ancillary medical providers that have contracted with the Contractor.

The subcontracts must further provide that the State shall not provide such indemnification to the subcontractor.

RFS #10-40
ATTACHMENT D
CONTRACTOR SCOPE OF WORK

Contractors that subcontract with prepaid health plans, physician-hospital organizations or another entity that accepts financial risk for services the Contractor does not directly provide must monitor the financial stability of subcontractor(s) whose payments are equal to or greater than five percent (5%) of premium/revenue. The Contractor must obtain the following information from the subcontractor at least quarterly and use it to monitor the subcontractor's performance:

- A statement of revenues and expenses
- A balance sheet
- Cash flows and changes in equity/fund balance
- IBNR estimates

At least annually, the Contractor must obtain the following additional information from the subcontractor and use this information to monitor the subcontractor's performance: audited financial statements including statement of revenues and expenses, balance sheet, cash flows and changes in equity/fund balance and an actuarial opinion of the IBNR estimates. The Contractor shall make these documents available to OMPP upon request and OMPP reserves the right to review these documents during Contractor site visits.

The Contractor must comply with 42 CFR 438.230 and the following subcontracting requirements:

- The Contractor must obtain the approval of OMPP before subcontracting any portion of the project's requirements. Subcontractors may include, but are not limited to a transportation broker, behavioral health organizations (BHOs) and Physician Hospital Organizations (PHOs). The Contractor must give OMPP a written request and submit a draft contract or model provider agreement at least sixty (60) calendar days prior to the use of a subcontractor. If the Contractor makes subsequent changes to the duties included in the subcontractor contract, it must notify OMPP sixty (60) calendar days prior to the revised contract effective date and submit the amendment for review and approval. OMPP must approve changes in vendors for any previously approved subcontracts.

- The Contractor must evaluate prospective subcontractors' abilities to perform delegated activities prior to contracting with the subcontractor to perform services associated with the Hoosier Healthwise and HIP programs.

- The Contractor must have a written agreement in place that specifies the subcontractor's responsibilities and provides an option for revoking delegation or imposing other sanctions if performance is inadequate. The written agreement must be in compliance with all the State of Indiana statutes, and will be subject to the provisions thereof. The subcontract cannot extend beyond the term of the State's Contract with the Contractor.

- The Contractor must collect performance and financial data from its subcontractors and monitor delegated performance on an ongoing basis and conduct formal, periodic and random reviews, as directed by OMPP. The Contractor must incorporate all subcontractors' data into the Contractor's performance and financial data for a comprehensive evaluation of the Contractor's performance compliance and identify areas for its subcontractors' improvement when appropriate. The Contractor must take corrective action if deficiencies are identified during the review.

- All subcontractors must fulfill all state and federal requirements appropriate to the services or activities delegated under the subcontract. In addition, all subcontractors must fulfill the requirements of the Contract (and any relevant amendments) that are appropriate to any service or activity delegated under the subcontract.

- The Contractor must comply with all subcontract requirements specified in 42 CFR 438.230. All subcontracts, provider contracts, agreements or other arrangements by which the Contractor intends to deliver services required under the RFS, whether or not characterized as a subcontract under the RFS, are subject to review and approval by OMPP and must be sufficient to assure the fulfillment of the requirements of 42 CFR 434.6. OMPP may waive its right to review subcontracts, provider contracts, agreements or other arrangements. Such waiver shall not constitute a waiver of any subcontract requirement.

The Contractor must have policies and procedures addressing auditing and monitoring subcontractors' data, data submissions and performance. The Contractor must integrate subcontractors' financial and performance data (as appropriate) into the Contractor's information system to accurately and completely report Contractor performance and confirm contract compliance.

OMPP reserves the right to audit the Contractor's subcontractors' self-reported data and change reporting requirements at any time with reasonable notice. OMPP may require corrective actions and will assess liquidated damages, as specified in Attachment B of the Contract, for non-compliance with reporting requirements and performance standards.

If the Contractor uses subcontractors to provide direct services to members, such as behavioral health services, the subcontractors must meet the same requirements as the Contractor, and the Contractor must demonstrate its oversight and monitoring of the subcontractor's compliance with these requirements. The Contractor must require subcontractors providing direct services to have quality improvement goals and performance improvement activities specific to the types of services provided by the subcontractors.

While the Contractor may choose to subcontract claims processing functions, or portions of those functions, with a state-approved subcontractor, the Contractor must demonstrate that the use of such subcontractors is invisible to providers, including out-of-network and self-referral providers, and will not result in confusion to the provider community about where to submit claims for payments. For example, the Contractor may elect to establish one post office box address for submission of all out-of-network provider claims. If different subcontracting organizations are responsible for processing those claims, it is the Contractor's responsibility to ensure that the subcontracting organizations forward claims to the appropriate processing entity. Use of a method such as this will not lengthen the timeliness standards discussed in Section 9.4.3. In this example, the definition of "date of receipt" is the date of the claim's receipt at the post office box.

2.9 Confidentiality of Member Medical Records and Other Information

The Contractor must ensure that member medical records, as well as any other health and enrollment information that contains individually identifiable health information, is used and disclosed in accordance with the privacy requirements set forth in the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule (see 45 CFR parts 160 and 164,

subparts A and E). The Contractor must also comply with all other applicable state and federal privacy and confidentiality requirements.

2.10 Internet Quorum (IQ) Inquires

The Contractor shall respond to IQ inquiries within the timeframe set forth by the Office. When forwarding an IQ inquiry to the Contractor for a response, OMPP shall designate that the inquiry is an IQ inquiry and will indentify when the Contractor's response is due. IQ inquiries typically include member, provider and other constituent concerns and require a prompt response. Failure by the Contractor to provide a timely and satisfactory response to IQ inquiries will subject Contractor to the liquidated damages set forth in Attachment B to the Contract.

2.11 Future Program Guidance

The State shall make its best efforts to publish a combined Hoosier Healthwise and HIP Managed Care Policies and Procedures Manual on or before the Contract award date and no later than the Contract start date. In addition to complying with the Managed Care Policies and Procedures Manual, the Contractor must operate in compliance with future program manuals, guidance and policies and procedures, as well as any amendments thereto. Future modifications that have a significant impact on the Contractor's responsibilities, as set forth in this Scope of Work, will be made through the Contract amendment process.

3.0 Billing and Collections

HIP eligibles and Hoosier Healthwise Package C (CHIP) eligibles are responsible for making a financial contribution to their health care coverage. These groups must make POWER Account contribution payments (HIP) or premium payments (Hoosier Healthwise Package C (CHIP)) in order to initiate and maintain enrollment in the programs. The Contractor shall be responsible for billing, collecting and applying these member payments. If a payment is not received within sixty (60) calendar days of its due date, the member will be terminated from the program.

The lowest Bidder shall also be responsible for collecting premiums on behalf of M.E.D. Works members, a separate IHCP program.

In July 2009, OMPP had approximately 36,000 open members and approximately 7,000 conditional members enrolled in Hoosier Healthwise Package C (CHIP) who are required to pay a premium. Of this population, there are approximately 12,500 payors. The payor is the person responsible for making the premium payments on behalf of the enrollee.

In July 2009, OMPP had approximately 45,316 open, or fully eligible, members and approximately 5,260 conditional members enrolled in HIP. Of these figures, 14,820 members were not required to pay a premium.

In July 2009, OMPP had approximately 2,800 open members and approximately 300 conditional members enrolled in the M.E.D. Works program who are required to pay a premium. Of this population, there are approximately 1,500 premium paying adults.

Collection services shall include:

- Creating and maintaining HIPAA compliant POWER Account contribution and premium billing services
- Generating and mailing invoices
- Receiving and posting payments
- Monitoring and tracking missed payments
- Processing returned checks
- Stopping or placing collections on hold as directed by the State
- Generating past due notices and other notifications
- Generating other informational materials as requested by the State
- Providing documentation of account activities and other financial reports
- Processing and mailing POWER Account contribution or premium refunds
- Transferring collected funds as requested by the State

- Documentation and reconciliation of funds received and transferred
- Establishing and handling separate lockboxes for Hoosier Healthwise Package C (CHIP), HIP and M.E.D. Works (if applicable)
- Providing services online that support and interface with the State's current website
- Ensuring the integrity and accuracy of data exchanged with or provided to the State, and that the data is compatible with other software, hardware or systems used by the State
- Ensuring compliance with current bankruptcy rules, the Cash Management Improvement Act of 1990 guidelines (Public Law 101-453), confidential information and electronic transaction processing procedures
- Adhering to established health care industry standards, in addition to any Medicaid rules, regulations and or mandates, as well as amendments thereto
- Date stamping mail received
- Maintaining a separate toll-free customer service phone number for M.E.D. Works (if applicable), which may be supplied by the State
- Maintaining separate bank accounts, Post Office boxes and reports for Hoosier Healthwise Package C (CHIP), HIP and M.E.D. Works (if applicable)
- Forwarding all change of address notifications and mail returned as undeliverable as specified by the State
- Transferring all Hoosier Healthwise Package C (CHIP) and M.E.D. Works receipts electronically to the State. Indiana Code 5-13-6-1 requires that all public funds collected by the State shall be deposited with the Treasurer of the State, or an approved depository selected by the Treasurer of the State, no later than the business day following the receipt of the funds. The Contractor shall notify FSSA financial management daily of the amount forwarded to the Treasurer of the State for that day.
- For Hoosier Healthwise Package C (CHIP) and M.E.D. Works premium collection activities, maintain an account balance not less than $5,000 in each bank account to maintain activity
- Provide monthly bank reconciliation reports in the form and manner set forth by the State

The State will calculate the required POWER Account contribution and premium amounts during the application process and will notify the Contractor of these amounts. The required premium will be provided in a monthly amount. The required POWER Account contribution will be provided in an annual benefit period amount. The Contractor must convert the benefit period POWER Account contribution amount to a monthly billing amount according to the Managed Care Policies and Procedures Manual.

POWER Account contributions and premiums will be recalculated by the State during redetermination. They may also be recalculated upon member request, as provided in Section 3.3 below.

3.1 Package C (CHIP) Premiums – Hoosier Healthwise

In order to participate in Hoosier Healthwise Package C (CHIP), the individual's family must pay a monthly premium. The monthly premium amounts are set forth in 407 IAC 2-3-1 and are based on a sliding scale. As of January 1, 2010, the Package C premiums are:

Income (by FPL)	One Child	Two or more children
Over 150 to 175%	$22	$33
Over 175 to 200%	$33	$50
Over 200 to 225%	$42	$53
Over 225 to 250%	$53	$70

In 2010, the State anticipates expanding CHIP eligibility to 300% of the FPL. After the expansion, the Package C premiums for the expansion population will be:

Income (by FPL)	One Child	Two or more children
Over 250 to 275%	$62	$73
Over 275 to 300%	$73	$90

The State will determine the amount of a family's Package C premium during the eligibility process and will notify the Contractor of this amount.

3.2 POWER Account Contributions – HIP

3.2.1 Individual POWER Account Contributions

In order to participate in HIP, individuals are required to help fund the $1,100 deductible by contributing to their POWER Account. Required contributions are based on a sliding scale, which does not exceed two to five percent (2-5%) of a member's gross annual family income and is reduced to account for any other payments being made by the member to Medicaid, Hoosier Healthwise or Medicare. Some members will have no required annual contribution.

The sliding scale for POWER Account contributions is set forth below. This sliding scale is subject to change by CMS or the State legislature.

- For members with annual household income of 100% FPL or less, the POWER Account contribution shall not exceed two percent (2%) of the member's annual household income

- For members with annual household income above 100% FPL and not more than 125% FPL, the POWER Account contribution shall not exceed three percent (3%) of the member's annual household income

- For members with annual household income above 125% FPL and not more than 150% FPL, the POWER Account contribution shall not exceed four percent (4%) of the member's annual household income

- For *parents and caretaker relatives* with annual household income above 150% FPL and not more than 200% FPL, the POWER Account contribution shall not exceed four and one-half percent (4.5%) of their annual household income

- For *non-caretakers* with annual household income above 150% FPL and not more than 200% FPL, the POWER Account contribution shall not exceed five percent (5%) of their annual household income

The State will determine the individual's required POWER Account contribution in an annual benefit period amount and will notify the Contractor of this amount. The State will also notify the Contractor if the member is not required to make an annual POWER Account contribution (i.e., "zero" contribution). For members with required contributions, the Contractor must convert the benefit period POWER Account contribution to a monthly billing amount according to the Managed Care Policies and Procedures Manual. The Contractor is not required to invoice members who, based on the sliding scale, are not required to pay an individual POWER Account contribution.

3.2.2 State POWER Account Contributions

The State will fund any gap between a member's required contribution (which will be capped at two to five percent (2-5%) of family income) and the $1,100 deductible. For example, if the member's annual income is $9,800 (100% FPL), their required contribution will be $196 (2% of $9,800 = $196) and the State's contribution will be $904 ($1,100 - $196 = $904). The State will make its entire contribution to the POWER Account promptly after receiving notice from the Contractor that the member's first POWER Account contribution has been processed. State contributions must be credited to a member's POWER Account upon receipt.

3.2.3 Employer POWER Account Contributions

Employers are permitted and encouraged to contribute to member POWER Accounts. As established in IC 12-15-44-10, an employer's contribution must be used to offset the employee's required contribution only—not the State's—and cannot exceed more than fifty percent (50%) of the employee's required contribution.

3.3 Recalculations

A member may request a recalculation of his or her POWER Account contribution or premium amount at any time if the individual experiences a change in family size, including a death, divorce, birth or family member moving out of the household. A member may also request a recalculation once every twelve (12) months (for Hoosier Healthwise Package C (CHIP)) or once

every benefit period (for HIP) if the member experiences a qualifying event. A "qualifying event" is defined as job loss or other change in income.

The Contractor must notify members of the circumstances in which they may request a POWER Account contribution or premium recalculation, and explain that the member will be responsible for notifying the State about changes in income.

The State will notify the Contractor if a member's POWER Account contribution or premium amount changes. The Contractor must begin billing the new POWER Account contribution or premium amount in the billing cycle immediately following the change.

3.4 Billing and Collections

The Contractor shall develop and mail invoices for Hoosier Healthwise Package C (CHIP), HIP and M.E.D. Works (if applicable) members that include the following information:

- The name of the Contractor
- First name, last name and address of payor
- First names of adult or child(ren) members
- Current monthly premium amount/POWER Account contribution owed
- Premium amount/POWER Account contribution past due
- Overpayment shown as credit
- Premium/POWER Account contribution due date
- Payor RID of the person responsible for payment
- Consequences of not paying the premium/POWER Account contribution
- Notice to send payment in all accepted forms, such as check, money order, on-line payment, unlimited electronic check or debit card via telephone, payroll deduction, automatic draft withdrawal from a designated account, cash payments or automated clearinghouse (ACH), including instructions on how to perform the transaction
- How to notify the Contractor of an address change
- How to notify the Contractor when individuals or families have billing questions or concerns
- Legal statement regarding bankruptcy, if applicable
- Any additional information as directed by OMPP

Regardless of whether the Contractor subcontracts the billing and collections function to another entity, invoices and any other related billing and collections materials must be sent under the Contractor's name, not the name of the subcontractor.

The Contractor shall translate invoices into the language specified by the member or the member's family. Currently, the State notifies the Contractor of Spanish-speaking members only.

At a minimum, the invoice mailing shall include an invoice with a detachable payment coupon and a return envelope without postage paid. Occasional one-page inserts may be required by OMPP to explain programmatic or billing changes. The Contractor shall provide members the option to sign-up and receive invoices via e-mail.

3.4.1 Initial POWER Account Contribution and Premium Payments

For HIP, Hoosier Healthwise Package C (CHIP) and M.E.D. Works (if applicable) eligibles, eligibility in the programs shall not be final until the first POWER Account contribution or premium is paid. Payment is due within sixty (60) calendar days of an individual's conditional eligibility date.

The Contractor shall receive conditional eligibility files of individuals that selected, or were auto-assigned to, their plan from the State. Within three (3) business days of receiving the conditional eligibility file, the Contractor shall send a Welcome Letter (for Hoosier Healthwise Package C (CHIP) and HIP only) and initial invoice to the individual for their first POWER Account contribution or premium payment. For Hoosier Healthwise Package C (CHIP) eligibles, the first invoice must reflect the monthly premium amount. For HIP eligibles, the first invoice must reflect one-twelfth (1/12) of the member's total required annual POWER Account contribution.

The Welcome Letter for Hoosier Healthwise Package C (CHIP) and HIP members must include a notice explaining that if the individual does not submit their initial payment within sixty (60) calendar days, their coverage under Hoosier Healthwise or HIP, as applicable, will not commence. The Welcome Letter must also have a notice prominently displayed on the first page stating in substance that the individual has the right to select another MCO before the first payment is made. As with all member communications, the Welcome Letter must be reviewed and approved by the State prior to use.

The Contractor must provide at least one reminder to individuals who have not made their first monthly POWER Account contribution or premium payment.

An individual's enrollment in the Contractor's plan begins the first day of the month after the first POWER Account contribution or premium payment is processed. The Contractor must process all payments and notify the State of the payment within ten (10) calendar days of receiving the payment. The ten (10)-calendar day period allows time to assure that payments made by check have cleared.

3.4.2 Ongoing Billing and Collections

The Contractor must bill for, and collect, POWER Account contributions and premiums on a monthly basis. Partial monthly payments are not permitted. In the RFS response, Bidders should propose methods to align invoices for families in both Hoosier Healthwise Package C

(CHIP) and HIP and provide for making combined payments for HIP and Hoosier Healthwise Package C (CHIP) members in the same family.

The Contractor must create a system to encourage members to make their POWER Account contributions and Hoosier Healthwise Package C (CHIP) premium payments. The system must include member education, outreach and reminders. Member education and outreach should be included in new member materials and coordinated with any contacts the Contractor makes with new members for health screenings and PMP selections.

The Contractor must notify members when the member fails to make a POWER Account contribution or premium payment by the due date. This reminder must be sent on or before the seventh (7^{th}) calendar day of non-payment and must include the following information:

- An explanation that if the member does not submit the past-due payment within sixty (60) calendar days of the original due date, as well as any subsequent overdue amounts, the member will be terminated from the program.

- An explanation that any final notice of termination from the program will come directly from the State and will include information about the individual's appeal rights.

- For HIP members only, a reminder that if the member is terminated from HIP for non-payment, the member will be not be able to participate in HIP for a period of twelve (12) months and that the member's portion of their POWER Account balance will be subject to a twenty-five percent (25%) penalty.

- A member helpline phone number for the member to call if they have any questions.

3.4.2.1 Payment Methods

The Contractor shall provide at least the following options for making payment:

- Check
- Money order
- Automatic payroll deduction
- Cash
- On-line payment via web portal. Please see Arizona Medicaid as an example: http://www.azahcccs.gov/members/premiums/premiums.aspx#Payment_Options.
- Unlimited electronic check or debit card payment via telephone
- Automatic draft withdrawal from a designated account
- Automated Clearinghouse (ACH)
- Electronic funds transfer

The cash payment process must be available through a statewide network of banks or other entities. In the case of a member with multiple employers, the Contractor is only required to provide the payroll deduction option for one of the member's employers at any given time. As an example, if the member changes employers, the member must be permitted to make payments via payroll deduction with the new employer; however, if a person has multiple jobs, it is only required that the Contractor be able to accept one payment via payroll deduction at a time. Innovation by the Contractor in assuring the collection of member payments is highly desired.

If applicable, HIP and Hoosier Healthwise Package C (CHIP) families must be permitted to make combined payments on behalf of all members in the same family in accordance with the Managed Care Policies and Procedures Manual.

Because POWER Account contributions are used to fund HIP members' $1,100 deductible, HIP eligibles and members must be permitted to pre-pay some or all of their annual POWER Account contribution upon request.

3.4.2.2 Employer POWER Account Contributions – HIP

In HIP, employers are permitted to contribute up to fifty percent (50%) of the member's annual POWER Account contribution. The Contractor must develop a program to publicize to members and employers that an employer may contribute to the member's POWER Account. Appropriate outreach materials should be developed and the Contractor must assure that its member services staff can address calls from members and employers on this topic. Communications about employer contributions should be on-going and continuous, and the Contractor should consider collecting member employment data in the health screening or other member contacts to use in its outreach efforts. The outreach materials for employers must identify the process the employer can use to contribute to employee POWER Accounts.

Employers shall be allowed to make POWER Account contribution payments on a monthly basis. The Contractor shall also allow employers to make their POWER Account contribution in one, lump sum payment upon request. The Contractor must ensure that lump sum payments are credited against the member's required POWER Account contributions evenly over the member's remaining term of coverage. If an employer fails to provide its share of a member's POWER Account contribution within sixty (60) calendar days of its due date, the member shall have an additional sixty (60) calendar days to pay the overdue amount before being terminated from HIP.

3.4.3 Non-Payment of Monthly POWER Account Contribution or Premium

If a member does not make a required POWER Account contribution or premium payment within sixty (60) calendar days of its due date, the member will be terminated from the program and must be disenrolled from the Contractor's plan. Payment via a dishonored check due to non-sufficient funds (NSF) will be considered non-payment, and members who have made such a payment will be terminated from the program if they are unable to provide the full POWER Account contribution or premium payment within sixty (60) calendar days of its original due date. If a member's check is returned for non-sufficient

funds, the Contractor may charge a reasonable fee for the returned check. The Contractor shall develop, print and mail notices to members if their payments are returned from the bank due to non-sufficient funds.

The Contractor must notify the State, through the Indiana Client Eligibility System (ICES), when a member does not pay their POWER Account contribution or premium within sixty (60) calendar days of its due date. This notification must be sent electronically to the State. The Contractor must wait until a termination record is received from the State to terminate the member from the plan.

If a member is disenrolled from HIP for non-payment, the Contractor must disable the member's POWER Account debit card immediately.

4.0 Personal Wellness & Responsibility (POWER) Accounts – HIP

The Contractor must establish and administer a POWER Account for each HIP member. HIP members will use the funds in their POWER Account to meet their $1,100 deductible.

As explained in Section 3 above, HIP members, the State and, in some cases, employers will contribute to the POWER Account. POWER Accounts are designed to provide incentives for members to stay healthy, be value- and cost-conscious and to utilize services in a cost-efficient manner as well as to seek price and quality transparency. HIP members must be aware that prudent management of their health care expenditures can leave them with available POWER Account funds at the end of the annual benefit period—and that these funds can be used to lower next year's contribution.

The POWER Account requirements set forth in this section apply only to the Contractor's HIP members. The Contractor must not provide POWER Accounts to its Hoosier Healthwise members. Please see the Bidder's Library for further detail regarding POWER Account policies and procedures. POWER Account technical requirements are in the process of being updated and shall be released in 2010. The Contractor shall be required to comply with the requirements set forth in these documents as of the effective date of the Contract.

4.1 POWER Account Administration

POWER Accounts will be funded in an amount equal to $1,100. Members, as well as the State, will contribute to their POWER Account. Employers are also encouraged to contribute to member POWER Accounts, but their contribution cannot exceed fifty percent (50%) of the member's contribution.

In families with two or more eligible adults, each member will have their own, individual POWER Account. Family members may choose to enroll in different MCOs.

4.2 Use of POWER Account Funds

Each member will be responsible for the use of funds in his or her POWER Account until the deductible is met. However, POWER Account funds can only be used by the member to pay for HIP covered services. A list of the HIP covered services is provided in Attachment E.

In spending POWER Account funds, members must be permitted to pay for the following covered services, even if obtained through out-of-network providers:

- Family planning services, if obtained from a IHCP provider
- Emergency medical services
- Other self-referral services outlined in Section 5.2, if obtained from a IHCP provider
- Medically necessary covered services, if the Contractor's network is unable to provide the service within a 60-mile radius of the member's residence, as specified in 42 CFR 438.206(b)(4) and Section 5.14
- Nurse practitioner services, if provided by an IHCP provider

Members shall not use POWER Account funds to pay for the emergency room services co-payment described in Section 5.6.3.

4.2.1 The POWER Account Debit Card

The Contractor must issue a POWER Account debit card to each new member and include it in the new member Welcome Packet. The new member Welcome Packet is due within five (5) calendar days of the member's enrollment in the Contractor's plan. The POWER Account debit card shall provide members with electronic access to their POWER Account funds. Each time a contribution to the member's POWER Account is made, the Contractor must credit the member's POWER Account debit card accordingly.

The Contractor must ensure that each POWER Account debit card is used only by members eligible on the date of service, and only to pay for covered services actually performed by IHCP providers. The Contractor shall establish safeguards to assure that the POWER Account debit card is not used to pay for non-covered services. The Contractor shall demonstrate to the satisfaction of OMPP these safeguards during the readiness review. The safeguards may require use of EBT-type card readers at contracted, in-network provider offices. The Contractor shall assist its network providers in developing the capability to conduct POWER Account debit card transactions following the Contract award but prior to the Contract effective date.

In the Bidder's response to the RFS, the Bidder shall identify the methods it will use to simplify POWER Account debit card operations and avoid or address potential issues such as the following:

- Member perception that the POWER Account debit card can be used to pay for any services, including non-covered services
- Provider confusion over when to use the POWER Account debit card and when to bill the Contractor for covered services
- Member and provider confusion, and operational issues, when services are paid for with the POWER Account debit card but subsequently denied by the Contractor

For covered, non-preventive services provided by out-of-network providers, or in-network providers that lack the capacity to conduct the transaction using the member's POWER Account debit card, the Contractor must instruct the provider to bill the Contractor for the service and must reimburse the provider with available funds in the member's POWER Account.

4.2.2 Replacement POWER Account Debit Cards

The Contractor must make replacement POWER Account debit cards available to members who lose or destroy their original POWER Account debit card at no cost to the member, as provided in 405 IAC 9-10-19.

4.2.3 Provider Reimbursement and the POWER Account

Participating providers shall be reimbursed at HIP rates (i.e., a rate not less than Medicare rates or 130% of Medicaid) when a member purchases covered services with POWER Account funds. In most cases, there will be sufficient funds in the member's POWER Account and the member will use his or her POWER Account debit card to reimburse the provider electronically and without cash at the point of service. In some cases however, the cost of the covered service may exceed the member's current POWER Account balance, even though the State will be making its entire POWER Account contribution at the beginning of the benefit period. For example, early in the benefit period the member will have only made a few contributions to the POWER Account. In this case, the member will use his or her POWER Account debit card to pay for the portion of the bill that his or her POWER Account funds can cover. The provider must be permitted to bill the Contractor for the remaining balance, and the Contractor must reimburse the provider for the balance according to its normal claims processing procedures. The Contractor can recover the funds it paid on the member's behalf with future POWER Account contributions paid by the member.

If a member obtains covered services from a provider that lacks the capacity to conduct a transaction with the member's POWER Account debit card, the provider must be allowed to bill the Contractor, and the Contractor must reimburse the provider with funds in the member's POWER Account.

4.3 POWER Account Balance Information

The Contractor shall maintain up-to-date member POWER Account balance information. This information must be mailed to members on a monthly basis in the form of a POWER Account Statement. It must also be available online via a secure member portal. The information must reflect real-time changes in the member's POWER Account, as evidenced by paid claims. It must also indicate the member's annual and monthly contribution amounts and the State's annual contribution amount.

POWER Account balance information must also be available to members by contacting the Contractor's Member Helpline. If possible, POWER Account balance information should be available in the form of a receipt at service locations where the POWER Account debit card is used.

The Contractor shall give members an opportunity to elect to receive e-mail alerts about updated POWER Account balance information on the member's secure member portal, in addition to or as an alternative to receiving the information by mail.

In providing the required POWER Account balance information, the Contractor may combine it with the Explanation of Benefit (EOB) information required in Section 6.4.5 below.

4.4 Interest

Neither members nor the Contractor may earn interest on POWER Accounts. On an annual basis, the Contractor shall report in the aggregate the interest accrued on its members' POWER Accounts. The Contractor must return this amount to the State.

4.5 Audit Requirement

The Contractor must engage an external entity to conduct an annual audit of its POWER Account operations and administration.

4.6 Redetermination and Roll Over

At the end of a benefit period, members shall have an opportunity to renew their eligibility in HIP by completing the redetermination process. If the member is redetermined eligible for HIP, any funds remaining in the member's POWER Account must be rolled over to reduce the amount of the member's required POWER Account contribution in the subsequent benefit period. The amount rolled over shall depend on whether the member received his or her recommended preventive care services. In order to allow a claims run-out period, roll over shall occur one hundred and eighty five (185) calendar days following the end of the member's benefit period.

In performing the roll over function, the Contractor shall comply with the procedures set forth in this section, as well as the additional policies and procedures included in the Bidder's Library and the Managed Care Policies and Procedures Manual. Please see the Bidder's Library for further detail regarding POWER Account policies and procedures. POWER Account technical requirements are in the process of being updated and shall be released in 2010. The Contractor shall be required to comply with the requirements set forth in these documents as of the effective date of the Contract. The Contractor must have the capability to transmit the required roll over data electronically as of the effective date of the Contract. This capability will be tested during the readiness review.

4.6.1 Recalculation of Member Contributions

Redetermination of member eligibility in HIP will occur every twelve (12) months and will be based on criteria set forth by the State. If a member is determined to remain eligible for HIP at the end of a benefit period, the member's POWER Account contribution will need to be recalculated for the new benefit period. The State will recalculate the member's POWER Account contribution based on any changes in the member's income recognized during redetermination.

The State fiscal agent will notify the Contractor of the member's POWER Account contribution for the new benefit period. After a one-hundred and eighty five (185) calendar day reconciliation period, the Contractor must report any roll over amounts to the State fiscal agent on the POWER Account Reconciliation file (PRF), as set forth in Sections 4.6.3 and 4.6.4 below. If necessary, the State will recalculate the member's POWER Account contribution. The Contractor must notify members of any roll over amounts, as well as any changes in their monthly POWER Account contribution due to roll over amounts.

Due to the fact that the first POWER Account installment in the new benefit period may become due before the member's individual contribution has been recalculated by the State,

the member may be billed by the Contractor according to the prior year's required contribution schedule. However, the Contractor will be required to reconcile any overpayments or underpayments made by the member after being notified by the State of the member's recalculated contribution amount for the new benefit period.

4.6.2 POWER Account Roll Over

If a member is redetermined eligible at the end of a benefit period, some or all of the funds remaining in the member's POWER Account must be rolled over into the next benefit period for purposes of reducing the member's required POWER Account contribution in the upcoming year. The amount of leftover funds available for roll over will depend on the member's utilization of recommended preventive care services. Each benefit period, OMPP will determine which recommended preventive care services apply to a specific member's age and gender, as well as the member's pre-existing conditions. Members that obtain all recommended preventive care services will be able to roll over their entire POWER Account balance, including monies contributed by the State. Members that fail to obtain the recommended preventive care services may only roll over their pro rata share of the POWER Account balance, leaving less money available to reduce the next year's required contribution. The remaining funds must be credited to the State.

Consider the following example:

A member contributes $400 to the POWER Account over the course of a benefit period and the State contributes $700, for a combined contribution of $1100 ($400 + $700 = $1100).

The member spends $450 of POWER Account funds to pay for covered services during the benefit period. At the end of the benefit period, $650 remains in the member's POWER Account ($1100 - $450 = $650).

If the member obtained the preventive care services recommended by OMPP for his or her age, gender and pre-existing conditions before the end of the benefit period, the entire $650 POWER Account balance will be available to be rolled over and used to reduce the member's required POWER Account contribution in the upcoming benefit period.

If the member did not obtain the preventive care services recommended by OMPP for his or her age, gender and pre-existing conditions before the end of the benefit period, only the member's pro rata share of the remaining POWER Account balance will be rolled over. In this case, the member's pro rata share would be $234 (4/11 or .36 x $650 = $234). $234 will be available to be rolled over and used to reduce the member's required POWER Account contribution in the upcoming benefit period. The Contractor must credit the remaining balance of $416 ($650 – $234 = $416) to the State.

If the roll over amount calculated to be available to the member is in excess of the member's required POWER Account contribution for the next benefit period, the excess amount will be credited to the State to reduce the State's contribution in the next benefit period. This shall occur regardless of whether the member obtained his or her recommended preventive care services. Under no circumstances will a member receive a roll over credit in excess of their next benefit period's contribution.

POWER Accounts are designed to encourage preventive care, the appropriate utilization of health care services and personal responsibility. Contractors must develop multiple methods of emphasizing to their members that responsible use of POWER Account funds, as well as obtaining recommended preventive care services, can lead to a reduced financial burden in the next benefit period. If members are aware that prudent management of their health care expenditures can leave them with available funds at the end of the annual benefit period—and that these funds can be used to lower their next year's contribution— members will be encouraged to make value- and cost-conscious decisions. See Section 6.4.4 for required POWER Account member education responsibilities.

4.6.3 Recommended Preventive Care Services

Each benefit period, OMPP will determine which recommended preventive services qualify a member for roll over. The Contractor must send preventive service reminders to their members throughout the benefit period, including in the monthly POWER Account Statements and redetermination correspondence.

The Contractor must have mechanisms in place to monitor when a member has obtained the preventive care services recommended for his or her age and gender, as well as pre-existing conditions, and report this information on the PRF one hundred and eighty five (185) calendar days following the end of the member's benefit period.

The Contractor shall monitor whether a member has received recommended preventive care services by:

1. Utilizing claims data to determine if any of the certain specified disease conditions exist;

2. Utilizing claims data to determine if required services have been obtained (OMPP shall provide the qualifying CPT and/or ICD-9 codes); and

3. If, after #1 and #2, preventive services cannot be verified, the Contractor may require the member to submit verification of preventive services.

Members will only be required to complete disease-specific preventive services if they were diagnosed with the disease prior to the beginning of the benefit period. If a disease develops mid-benefit period, the member will not be required to complete preventive care services related to that disease until the next benefit period.

Ninety (90) calendar days prior to the end of a member's benefit period, the Contractor shall make an initial assessment (through claims and other information, as described above) of whether the member has completed the recommended preventive services. If the member has not received recommended preventive services, the Contractor shall send a reminder to the member. The reminder must notify the member that the Contractor's records indicate that the member **has not** received recommended preventive services based on medical claims received as of a specified date. A general listing that outlines what was required for different ages, genders and disease types is sufficient, it does not need to be specific to the member. The reminder must also explain that if the member receives the recommended preventive services, the member will be eligible to roll over the entire remaining POWER Account balance at the end of the benefit period, including the State's contribution. This

correspondence should be coordinated with other redetermination reminders and shall be provided no later than sixty (60) calendar days prior to the end of the member's benefit period.

Ninety (90) calendar days after the end of a member's benefit period, the Contractor shall make an assessment (through claims and other information, as described above) of whether the member has completed the recommended preventive services. The Contractor must send a letter to the member informing the member of its assessment if the assessment indicates that the member has not received the recommended preventive care. This letter must go out within the ninety (90) calendar day period.

1. The letter to the member does not need to spell out what services the member received and what were not received. The letter must only indicate that all of the required preventive care services were not completed.

2. The letter to the member must list what the required preventive care services were for the member's benefit period. A general listing that outlines what was required for different ages, genders and disease types is sufficient, it does not need to be specific to the member.

3. The Contractor must develop a form that can be easily completed by a member's physician which verifies that the member's age and sex appropriate services have been obtained. This form must be included in the letter to the member.

4. If the Contractor's records indicated that the member has not received the recommended preventive services, the Contractor must allow the member to file a grievance on the decision by submitting documentation that indicates that they did in fact receive the required preventive care. The form included in the member's letter can be used as supporting documentation, but must be completed by the member's physician.

5. The letter must indicate that the member has sixty (60) calendar days from receipt of the letter to file a grievance on the decision and submit additional information using the attached form. The Contractor may incorporate this grievance process into their existing grievance and appeals process, but must ensure that the grievance is resolved in a time period that allows for timely submission of a complete and accurate PRF to the State.

6. If a member changes MCOs during redetermination, the Contractor (e.g., original MCO) is responsible for sending out the letter and giving the member an opportunity to file a grievance.

Example language that should be included in the letter to the member includes:

- The required preventive service(s) for the year was "X". If you received the required preventive services, you will be able to roll over your entire remaining POWER Account balance at the end of the benefit period.

- A preliminary review of our records indicate that you have not received the required preventive service(s).

- If you believe our preliminary determination is in error and you have received the preventive services listed above, please fill out the attached form and submit it to "X". The form must be filled out by your physician and returned within sixty (60) calendar days.

Further detail regarding preventive service monitoring and reporting is set forth in the Managed Care Policies and Procedures Manual.

4.6.4 POWER Account Reconciliation – Eligibility Renewal and Rollover

In the event a member renews his or her eligibility in HIP at the end of a benefit period, the POWER Account reconciliation process occurs in two stages:

- Member rollover and the State's refund: One hundred and eighty five (185) calendar days from the end of the benefit period

- Final reconciliation: Five hundred and seventy (570) calendar days from the end of the benefit period, only in instances where an appeal is associated with a claim

One hundred and eighty five (185) calendar days after the conclusion of a benefit period, the Contractor must notify the State of whether the member obtained the recommended preventive services and the amount, if any, of the member's POWER Account that will be rolled over to reduce the next benefit period's required contribution. This notice must also indicate the amount, if any, of the member's POWER Account that will be credited back to the State due to the member's failure to obtain recommended preventive care services (i.e., the State's pro rata share) and other data. This information must be provided on the PRF, which is an electronic transaction between the Contractor and the State fiscal agent. POWER Account technical requirements, including the PRF, are in the process of being updated and shall be released in 2010. The Contractor shall be required to comply with these requirements as of the effective date of the Contract. Member roll over amounts and the State's refunds must be reported even if the amount is zero, in order to verify to the State that the reconciliation process is finalized. Any amounts reported as owed to the State will be transferred to the State via the 820 transaction.

Although the PRF is filed one hundred and eighty five (185) calendar days following the end of the member's benefit period, the Contractor can make adjustments up to five hundred and seventy (570) calendar days after the end of the benefit period based on appeals made by providers and members that result in adjustments as follows:

- If a claim comes in after a member's POWER Account has been reconciled and rolled over, the Contractor must determine if there are dollars owed by the State and the member based on the same percentages used to create and administer the member's POWER Account.

- For any claim paid after the POWER Account has been reconciled and rolled over, the Contractor must notify the State fiscal agent of the State portion due. The State fiscal agent will pay this amount via the 820 transaction.

- The Contractor shall not readjust the member's roll over amount based on appealed claims.

Please see the Bidder's Library for further detail regarding POWER Account policies and procedures. POWER Account technical requirements are in the process of being updated and shall be released in 2010. The Contractor shall be required to comply with these requirements as of the effective date of the Contract.

4.7 Termination of Eligibility

If a member becomes ineligible for HIP, either during redetermination or at another time, the Contractor must close the member POWER Account and refund the State and member share of the remaining POWER Account balance, if any. This includes when a HIP member becomes pregnant and enrolls in Hoosier Healthwise to receive pregnancy-related services.

The member's share of the remaining POWER Account balance must be refunded within sixty (60) calendar days of the member's date of termination from HIP. The State share must be reported one hundred and eighty five (185) calendar days following the member's termination from HIP.

In performing the POWER Account reconciliation function when a member loses eligibility, the Contractor shall comply with the procedures set forth in this section, as well as the additional policies and procedures included in the Bidder's Library and Managed Care Policies and Procedures Manual. POWER Account technical requirements are in the process of being updated and shall be released in 2010. The Contractor shall be required to comply with these requirements as of the effective date of the Contract. The Contractor must have the capability to transmit the required reconciliation data electronically as of the effective date of the Contract. This capability will be tested during the readiness review.

4.7.1 Member Refund

If a member becomes ineligible for HIP, either during redetermination or at another time, the Contractor must refund the member's share of his or her POWER Account balance, if any, **within sixty (60) calendar days** of the member's date of termination from HIP. If the Contractor sends a POWER Account refund check to a member and the check is returned to the Contractor because the member cannot be located, the Contractor shall handle the member's unclaimed refund pursuant to Indiana Statute (IC 32-34-1, et seq.).

A deceased member's estate will have a right to the member's pro rata share of his or her POWER Account funds.

Unless a member is terminated from HIP due to non-payment, the amount payable to the member shall be determined as follows:

- Step One: Determine the amount paid into the POWER Account to date by the individual and the individual's employer (if any)

- Step Two: Determine the total amount paid into the individual's POWER Account from all sources

- Step Three: Divide the amount determined in Step One by the amount determined in Step Two

- Step Four: Multiply the ratio determined in Step Three by the total amount remaining in the POWER Account

When a member is terminated from HIP for non-payment, or if a member voluntarily withdraws from HIP, the member will forfeit to the State twenty-five percent (25%) of his or her pro rata share of any funds remaining in the member's POWER Account. This means that upon member termination from HIP due to non-payment, the Contractor shall be required to refund only a portion of the member's pro rata share of the POWER Account. The amount payable to the member shall be determined as follows:

- Step One: Determine the amount paid into the POWER Account to date by the individual and the individual's employer (if any)

- Step Two: Determine the total amount paid into the individual's POWER Account from all sources

- Step Three: Divide the amount determined in Step One by the amount determined in Step Two

- Step Four: Multiply the ratio determined in Step Three by the total amount remaining in the POWER Account

- Step Five: Multiply the amount determined under Step Four by seventy-five hundredths (.75 or 75%)

4.7.2 State Refund

Any funds remaining in the POWER Account after the member rebate must be credited to the State via the 820 transaction. The Contractor will have one hundred and eighty five (185) calendar days from the member's date of termination from the plan to report the amount to the State.

4.7.3 POWER Account Reconciliation

In the event of member termination, the POWER Account reconciliation process occurs in three stages:

- Member refund: Sixty (60) calendar days from date of member termination

- State refund: One-hundred and eighty five (185) calendar days from date of member termination

- Final reconciliation: Five hundred and seventy (570) calendar days from date of member termination, only in instances where an appeal is associated with a claim

One hundred and eighty five (185) calendar days following a member's termination, the Contractor must notify the State fiscal agent of the amount of the member and state refunds, annual and lifetime benefit information, member debt and other data. This information must be provided on the PRF, which is an electronic transaction between the Contractor and the State fiscal agent. Please see the Bidder's Library for further detail regarding POWER Account policies and procedures. POWER Account technical requirements, including the PRF, are in the process of being updated and shall be released in 2010. The Contractor shall be required to comply with these requirements as of the effective date of the Contract.

Member and state refunds must be reported even if the amount is zero, in order to verify to the State that the reconciliation process is finalized. Any amounts reported as owed to the State will be transferred to the State via the 820 transaction.

Although the PRF is filed one hundred and eighty five (185) calendar days following a member's termination, the Contractor can make adjustments up to five hundred and seventy (570) calendar days after member termination based on appeals made by providers and members that result in adjustments as follows:

- If a claim comes in after a member's POWER Account has been reconciled and/or a member refund has been issued, the Contractor must determine if there are dollars owed by the State and the member based on the same percentages used to create and administer the member's POWER Account.

- For any claim paid after the POWER Account has been reconciled and/or a member refund has been issued, the Contractor must notify the State fiscal agent of the State portion due. The State fiscal agent will pay this amount via the 820 transaction.

- The Contractor shall not pursue the member's portion of an appealed claim after a member refund is made.

Please see the Bidder's Library for further detail regarding POWER Account policies and procedures. POWER Account technical requirements are in the process of being updated and shall be released in 2010. The Contractor shall be required to comply with these requirements as of the effective date of the Contract.

4.8 POWER Account Debt Collection Process

For members that are terminated from HIP before their POWER Account is fully funded, the Contractor may register and collect any debt owed by the member to the Contractor. The Contractor shall register the debt with the State fiscal agent. The State fiscal agent will document the debt owed and the MCO to whom the debt is owed.

If the Contractor pursues the member debt, the Contractor must do so in accordance with standard company practice for collection of debt in the individual market segment. The Contractor shall not sell the member's debt.

When the debt is resolved (i.e., paid by the member), the Contractor must notify the State fiscal agent so that the debt can be end dated in the State fiscal agent's system.

The Contractor will be notified if an individual that owes a debt to the Contractor reapplies for HIP. In this case, the Contractor must send a letter to the individual explaining that until their debt is paid, they cannot participate in HIP and that they have sixty (60) calendar days to clear the debt and pay their first POWER Account contribution. If Contractor collects the debt, they must notify the State fiscal agent that the debt is cleared.

See the Managed Care Policies and Procedures Manual for further information regarding the debt collection process.

4.9 POWER Account Balance Transfers

If a member transfers to another MCO or the ESP during their benefit period, the Contractor must transfer the member's POWER Account balance to the State fiscal agent within thirty (30) calendar days of notification of the transfer. The Contractor must also complete the Plan to Plan Transfer Spreadsheet, which shall include POWER Account balance information (including member contribution paid and POWER Account claims paid) for the new MCO or the ESP, as applicable.

If the member transfer occurs at the end of the benefit period, the Contractor remains responsible for determining the amount of member roll over, as well as any amounts that must be credited back to the State. The Contractor will be required to forward the roll over amount to the State and credit to the State its share of the POWER Account balance, as described above. The Plan to Plan Transfer Spreadsheet is not required in these cases.

5.0 Covered Benefits and Services

The Contractor must provide to its Hoosier Healthwise and HIP members, at a minimum, all benefits and services deemed "medically reasonable and necessary" and covered under the Contract with the State. A covered service is medically necessary if, in a manner consistent with accepted standards of medical practice, it is reasonably expected to:

- Prevent or diagnose the onset of an illness, injury, condition, primary disability or secondary disability.
- Cure, correct, reduce or ameliorate the physical, mental, cognitive or developmental effects of an illness, injury or disability.
- Reduce or ameliorate the pain or suffering caused by an illness, injury, condition or disability.

The Contractor must deliver covered services sufficient in amount, duration or scope to reasonably expect that provision of such services would achieve the purpose of the furnished services. Costs for these services are the basis of the Contractor's capitation rate and are, therefore, the responsibility of the Contractor. Coverage may not be arbitrarily denied or reduced and is subject to certain limitations in accordance with 42 CFR 438.210(a)(3)(iii) regarding:

- Medical necessity determinations.
- Utilization control, provided the services furnished are sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are furnished.

5.1 Covered Benefits and Services

5.1.1 Covered Benefits and Services – Hoosier Healthwise

Hoosier Healthwise covered services include all Medicaid (Packages A and B), Presumptive Eligibility (Package P) and CHIP (Package C) covered services. The Indiana Administrative Code at 407 IAC 3 sets forth the CHIP Package C covered services and the Indiana Administrative Code 405 IAC 5 details the Medicaid covered services. The Indiana Administrative Code at 405 IAC 2-3.2 sets forth the Package P covered services. Attachment E of the RFS provides a general description of the Hoosier Healthwise benefit packages and the services and benefits that are available.

5.1.2 Covered Benefits and Services – HIP

HIP covered services include all services identified in IC 12-15-44 and 405 IAC 9-7. As stated in IC 12-15-44-4, the Contractor must also comply with any coverage requirements that apply to an accident and sickness insurance policy issued in Indiana. HIP covered services are subject to an $1,100 annual deductible, to be paid with POWER Account funds, and a $300,000 annual and $1,000,000 lifetime benefit maximum. Attachment E of the RFS provides a general description of the HIP benefit package and the services and benefits that are available.

Contractors must reimburse both in- and out-of-network HIP providers for covered services at a rate not less than 1) Medicare reimbursement or 2) 130% of Medicaid rates if the service does not have a Medicare reimbursement rate. Pursuant to 405 IAC 9-8-1(b), in instances where the Contractor pays for a service at the Medicare rate, any cost-sharing typically applicable in the Medicare program is not applicable and will be included in the rate paid by the Contractor.

5.2 Self-referral Services

In accordance with state and federal requirements, the Hoosier Healthwise and HIP programs include some benefits and services that are available to members on a self-referral basis. In most cases, these self-referral services shall not require a referral from the member's PMP or authorization from the Contractor.

The Contractor must include self-referral providers in its contracted network. The Contractor and its PMPs may direct members to seek the services of the self-referral providers contracted in the Contractor's network. However, with the exception of behavioral health services, the Contractor cannot require that the members receive such services from network providers. Hoosier Healthwise and HIP members may self-refer to any IHCP provider qualified to provide the service(s).

When Hoosier Healthwise members choose to receive self-referral services from IHCP-enrolled self-referral providers who do not have contractual relationships with the Contractor, the Contractor is responsible for payment to these providers up to the applicable benefit limits and at Indiana Medicaid FFS rates.

With the exception of family planning services and emergency services, when HIP members choose to receive self-referral services from IHCP-enrolled self-referral providers, they must go

to an in-network provider or receive prior authorization to go to an out-of-network provider. The Contractor is responsible for payment for self-referral services up to the applicable benefit limits and at a rate not less than Medicare rates or 130% of Medicaid if there is no Medicare rate.

Members may not self-refer to a provider who is not enrolled in IHCP. The following services are considered self-referral services. The Indiana Administrative Code 405 IAC 5 (Hoosier Healthwise) and 405 IAC 9-7 (HIP) provides further detail regarding these benefits.

- Chiropractic services (Hoosier Healthwise only) may be provided by a licensed chiropractor, enrolled as an Indiana Medicaid provider, when rendered within the scope of the practice of chiropractic as defined in IC 25-10-1-1 and 846 IAC 1-1.

- Eye care services, except surgical services (Hoosier Healthwise only) may be provided by any provider licensed under IC 25-22.5 (doctor of medicine or doctor of osteopathy) or IC 25-24 (optometrist) who has entered into a provider agreement under IC 12-15-11.

- Podiatric services (Hoosier Healthwise only) may be provided by any provider licensed under IC 25-22.5 (doctor of medicine or doctor of osteopathy) or IC 25-29 (doctor of podiatric medicine) who has entered into a provider agreement under IC 12-15-11.

- Psychiatric services may be provided by any provider licensed under IC 25-22.5 (doctor of medicine or doctor of osteopathy) who has entered into a provider agreement under IC 12-15-11.

- Family planning services under federal regulation 42 CFR 431.51(b)(2) require a freedom of choice of providers and access to family planning services and supplies. Family planning services are those services provided to individuals of childbearing age to temporarily or permanently prevent or delay pregnancy. Family planning services also include sexually transmitted disease testing. Abortions and abortifacients are not covered family planning services, except as allowable under the federal Hyde Amendment. Members may self-refer to any IHCP provider qualified to provide the family planning service(s), including providers that are not in the Contractor's network. Members may not be restricted in choice of a family planning service provider, so long as the provider is an IHCP provider. The IHCP Provider Manual provides a complete and current list of family planning services.

  The Contractor must provide all covered family planning services and supplies, with the exception of the following items which, to the extent included in 405 IAC 5-24 and 405 IAC 9-7 as covered, will be reimbursable by Indiana Medicaid FFS under the pharmacy benefit consolidation when provided by an Indiana Medicaid enrolled pharmacy or DME provider, as applicable:

  - Legend drugs
  - Non-legend drugs
  - Diaphragms
  - Spermicides (Hoosier Healthwise only)

- Condoms (Hoosier Healthwise only)
- Cervical caps

If the family planning services and supplies listed above are provided by a provider type other than a pharmacy or DME provider, the Contractor remains responsible for reimbursing for the service or supply.

- HIV/AIDS targeted case management services (Hoosier Healthwise only) are limited to no more than sixty (60) hours per quarter and are available to Package A and Package B members. For more detailed information concerning a member's self-referral for HIV/AIDS targeted case management services, see the IHCP Provider Manual.

- Emergency services are covered without the need for prior authorization or the existence of a Contractor contract with the emergency care provider. Emergency services must be available twenty four (24)-hours-a-day, seven (7)-days-a-week subject to the "prudent layperson" standard of an emergency medical condition, as defined in 42 CFR 438.114 and IC 12-15-12. See Section 5.6 for more information.

- Immunizations are self-referral to any IHCP-enrolled provider. Immunizations are covered regardless of where they are received.

- Diabetes self-management services are self-referral if rendered by a self-referral provider. See Section 5.10 for more detail.

- Behavioral health services are self-referral if rendered by an in-network provider. Members may self-refer, within the Contractor's network, for behavioral health services not provided by a psychiatrist, including mental health, substance abuse and chemical dependency services rendered by mental health specialty providers. The mental health providers to which the member may self-refer within network are:

  - Outpatient mental health clinics
  - Community mental health centers
  - Psychologists
  - Certified psychologists
  - Health services providers in psychology (HSPPs)
  - Certified social workers
  - Certified clinical social workers
  - Psychiatric nurses
  - Independent practice school psychologists
  - Advanced practice nurses under IC 25-23-1-1(b)(3), credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center
  - Persons holding a master's degree in social work, marital and family therapy or mental health counseling (under the Clinic Option)

5.3 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services

EPSDT is a federally-mandated preventive health care program designed to improve the overall health of Medicaid-eligible infants, children and adolescents from birth to twenty-one (21) years old.

5.3.1 EPSDT Services – Hoosier Healthwise

HealthWatch is the name of Indiana's EPSDT program. HealthWatch services are available for all Hoosier Healthwise members. HealthWatch includes all IHCP-covered preventive, diagnostic and treatment services, as well as other prior-authorized treatment services that the screening provider determines to be medically necessary.[2]

The primary goal of HealthWatch is to ensure that children enrolled in IHCP receive age-appropriate comprehensive, preventive services. Early detection and treatment can reduce the risk of more costly treatment or hospitalization resulting from delayed treatment. See the IHCP HealthWatch EPSDT Provider Manual for details regarding components and recommended frequency of HealthWatch screenings.

OMPP encourages Contractors to work with prenatal clinics and other providers to educate pregnant women about the importance of EPSDT screenings and encourage them to schedule preventive visits for their infants.

Lead level screening is an important component of HealthWatch. Based on the State's obligation to monitor the Contractor's performance in this area, in accordance with IC-12-15-12-20, OMPP requires Contractors to screen children for lead poisoning. It is a priority for OMPP that all IHCP children between nine (9) months and six (6) years are tested for lead poisoning and that children with elevated lead levels are identified and receive the recommended follow-up treatment. Lead poisoning may cause anemia, permanent brain damage, learning disorders, loss of balance, kidney damage, blindness, hearing loss, seizures, coma and death. With early screening and treatment, the serious effects of lead poisoning can be prevented.

The Contractor must provide all covered EPSDT services, with the exception of legend and non-legend drugs which are covered by Indiana Medicaid FFS under the pharmacy benefit consolidation. In covering well-child visits, the Contractor shall follow the latest guidance from the American Academy of Pediatrics (AAP).

5.3.2 EPSDT Services – HIP

The Contractor must cover lead screening and hearing aids for nineteen (19) and twenty (20) year old HIP members. Lead screening services are a preventive service and are not subject to the $1,100 deductible.

5.4 Pharmacy Benefit Consolidation

Except as provided herein, Contractors are not responsible for the coverage of legend drugs, non-legend drugs included on the Medicaid non-legend drug formulary and medical supplies

[2] For CHIP, coverage of treatment services is limited to the Package C benefit package coverage limitations.

and medical devices identified in this section as being reimbursable by the Indiana Medicaid FFS program under the pharmacy benefit consolidation. These services will be provided to the Contractor's members under the Indiana Medicaid FFS program.

Pharmacy-related medical supplies and medical devices that are not the Contractor's responsibility are listed in the table below. These items are reimbursable by Indiana Medicaid FFS under the pharmacy benefit consolidation when provided by an Indiana Medicaid enrolled pharmacy or DME provider. If provided by another provider type, the Contractor remains responsible for covering the pharmacy-related item. The Contractor is also responsible for covered pharmacy-related medical supplies and medical devices not specifically identified as being reimbursable by Indiana Medicaid FFS under the pharmacy benefit consolidation.

This list of pharmacy-related medical supplies and medical devices reimbursable by Indiana Medicaid FFS under the pharmacy benefit consolidation is subject to expansion but not contraction. Any additions to the list of pharmacy-related medical supplies and medical devices reimbursable by Indiana Medicaid FFS under the pharmacy benefit consolidation will be communicated to Contractors in a provider bulletin or other formal communication at least forty-five (45) calendar days prior to the change.

Pharmacy-Related Medical Supplies and Medical Devices Reimbursable by Indiana Medicaid FFS Under the Pharmacy Benefit Consolidation:

Procedure Code	Description
A4210	Needle free injection device
A4211	Supplies for self administered injection
A4245	Alcohol wipes, per box
A4206	Syringe with needle; sterile , 1cc or less, each
A4207	Sterile 2cc, each
A4208	Sterile 3cc, each
A4209	Sterile 5cc or greater, each
A4213	Syringe, sterile, 20cc or greater, each
A4215	Needle, sterile, any size, each
A4233	Replacement battery, alkaline (other than J cell), for use with medically necessary home blood glucose monitor owned by patient, each
A4234	Replacement battery, alkaline, J cell, for use with medically necessary home blood glucose monitor owned by patient, each
A4235	Replacement battery, lithium, for use with medically necessary home blood glucose monitor owned by patient, each
A4236	Replacement battery, silver oxide, for use with medically necessary home blood glucose monitor owned by patient, each
A4244	Alcohol or peroxide, per pint
A4250	Urine test or reagent strips or tablets (100 tablets or strips)
A4253	Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips
A4256	Normal, low and high calibrator solutions/chips
A4258	Lancet device
A4259	Lancets, per box of 100
A4261	Cervical cap for contraceptive use
A4266	Diaphragm for contraceptive use
A4267	Contraceptive supply, condom, male, each (covered service in Hoosier Healthwise only)
A4268	Contraceptive supply, condom, female, each (covered service in Hoosier Healthwise only)
A4269	Contraceptive supply, spermacide (e.g., foam, gel) (covered service in Hoosier Healthwise only)
A4627	Spacer, bag or reservoir, with or without mask, for use with metered dose inhaler
A7018	Water, distilled, used with large volume nebulizer, 1000 ml
E0607	Home blood glucose monitor
E2100	Blood glucose monitor with integrated voice synthesizer
E2101	Blood glucose monitor with integrated lancing/blood sample
S8101	Holding Chamber or spacer for use with an inhaler or nebulizer; with mask
S8100	Holding chamber or spacer for use with an inhaler or nebulizer without mask

The Contractor remains responsible for the following services. These services are not reimbursable by Indiana Medicaid FFS under the pharmacy benefit consolidation:

1. Procedure coded drugs billed to the Contractor by entities other than Medicaid enrolled pharmacy providers. For procedure coded claims involving covered outpatient drugs, the Contractor shall require submission of the National Drug Code as required by federal regulation or guidance.
2. Medical supplies and medical devices not identified as being reimbursable by Indiana Medicaid FFS under the pharmacy benefit consolidation in this Section or Section 5.2
3. DME
4. Enteral or oral nutritional supplements

The Contractor may not deny payment for procedure coded drugs, as referred to in Item #1 above, unless the drug is readily available from an enrolled Medicaid pharmacy provider, and the provision of the drug is in conformance with all applicable laws and does not result in any compromise to patient care and/or increased program costs. The Contractor must assure the following before denying payment for a procedure coded drug:

1. The drug is readily available from an enrolled Medicaid pharmacy provider;
2. The provision of the drug by the enrolled Medicaid pharmacy provider does not compromise the delivery of quality care; and
3. Written approval to deny payment for the procedure coded drug is provided by OMPP.

The Contractor shall request prior written approval by OMPP before denying payment for any procedure coded drug. An approval by OMPP to deny payment may be revoked by OMPP at any time with notice to the Contractor. OMPP may monitor denied claims for procedure coded drugs.

Although Contractors are not responsible for paying or reimbursing most pharmacy services, Contractors must remain actively involved in monitoring pharmacy utilization, physician prescribing patterns, member compliance with taking prescribed medications and other analytic activities with the goal of maximizing the health outcomes of their membership. Contractors must assist members with medication management. Contractors shall utilize the pharmacy data made available by the State in an effort to ensure that members are refilling prescriptions appropriately and provide outreach to members that are not in compliance. OMPP shall monitor the Contractor's utilization and care management activities through its monthly onsite visits and/or external quality review activities to ensure that the Contractor is integrating pharmacy data into its utilization and care management activities. The Contractor may be subject to non-compliance remedies as set forth in Attachment B to the Contract if the Contractor fails to integrate pharmacy data into its utilization and care management activities.

Contractors will coordinate with the State's PBM to reduce pharmacy costs through various strategies, such as examining and increasing the dispensing rate of generic medications or encouraging their provider network to prescribe a generic medication within a class before automatically prescribing brand drugs.

Contractors will take appropriate steps to monitor pharmacy claims, provide input regarding suggested changes and improvements to the preferred drug list and/or policies and procedures to the State. The Contractor must provide representation at all meetings of the State's Drug

Utilization Review (DUR) Board, public meetings of the Therapeutics Committee and meetings of the Mental Health Quality Advisory Committee. Appropriate Contractor staff shall make presentations at these meetings if requested by OMPP, and the Contractor's Medical Director or his or her designee shall participate in a monthly conference call with OMPP pharmacy staff to provide input regarding potential improvements to the pharmacy benefit program.

The Contractor's Medical Director, in close coordination with other key staff, is responsible for ensuring all of the Contractor's pharmacy-related operations are in compliance with OMPP pharmacy policies and the terms of the Contract. The Medical Director will communicate with the Contractor's executive leadership and staff, OMPP, the State's contractors and other parties with the goal of promoting medication adherence and promotion and measurement of positive health outcomes among the Contractor's membership. The Medical Director or his or her designee will coordinate with and actively assist staff of the State's PBM in addressing clinically-related matters (prior authorization and otherwise) that involve members of the Contractor and that are escalated at or involve the State PBM's clinical call center. In providing assistance, the Medical Director or his or her designee shall utilize the State PBM's Executive Account Manager, or other staff as directed by OMPP, as the primary point of contact at the State's PBM.

In HIP, the Contractor shall accept, in the form, manner and schedule set forth by the State, pharmacy and drug related medical device and supply claims data from the State fiscal agent. The Contractor shall utilize this data to update member POWER Account balances, as well as members' cumulative annual and lifetime benefit totals, as applicable.

From the pharmacy and drug related medical device and supply claims data provided by the State fiscal agent, the Contractor shall provide, in the form, manner and schedule set forth by the State, pharmacy and drug related medical device and supply claims amounts that were satisfied by a member's POWER Account. The State shall recoup all pharmacy and drug related medical device and supply claims amounts satisfied by a member's POWER Account.

5.5 Smoking Cessation Services

The Contractor must cover, at minimum, smoking cessation services as set forth in 405 IAC 5-37. 405 IAC 5-37-3 is in the process of being amended and is likely to cover eight (8) sessions of tobacco cessation counseling services per member, per rolling twelve (12) months. Pharmacotherapy treatment shall be reimbursable by Indiana Medicaid FFS under the pharmacy benefit consolidation.

5.6 Emergency Care

The Contractor must cover emergency services without the need for prior authorization or the existence of a contract with the emergency care provider. Services for treatment of an emergency medical condition, as defined in 42 CFR 438.114 and IC 12-15-12 (i.e., subject to the "prudent layperson" standard), must be available twenty four (24)-hours-a-day, seven (7)-days-a-week.

The Contractor must cover the medical screening examination, as defined by the Emergency Medical Treatment and Active Labor Act (EMTALA) regulations at 42 CFR 489.24, provided to a member who presents to an emergency department with an emergency medical condition. The

Contractor must also comply with all applicable emergency services requirements specified in IC 12-15-12. In Hoosier Healthwise, the Contractor must reimburse out-of-network providers at 100% of the Medicaid rate unless other payment arrangements are made. In HIP, the Contractor must reimburse out-of-network providers at the Medicare rate or, if there is no Medicare rate, at 130% of Medicaid unless other payment arrangements are made. The Contractor is required to reimburse for the medical screening examination and facility fee for the screening but is not required to reimburse providers for services rendered in an emergency room for treatment of conditions that do not meet the prudent layperson standard as an emergency medical condition, unless the Contractor authorized this treatment.

In accordance with 42 CFR 438.114, the Contractor may not determine what constitutes an emergency on the basis of lists of diagnoses or symptoms. The Contractor may not deny payment for treatment obtained when a member had an emergency medical condition, even if the outcomes, in the absence of immediate medical attention, would not have been those specified in the definition of emergency medical condition. The Contractor may not deny or pay less than the allowed amount for the CPT code on the claim without a medical record review. When the Contractor conducts a prudent layperson review to determine whether an emergency medical condition exists, the reviewer must not have more than a high school education and must not have training in a medical, nursing or social work-related field.

The Contractor is prohibited from refusing to cover emergency services if the emergency room provider, hospital or fiscal agent does not notify the member's PMP or the Contractor of the member's screening and treatment within ten (10) calendar days of presentation for emergency services. The member who has an emergency is not liable for the payment of subsequent screening and treatment that may be needed to diagnose or stabilize the specific condition. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge. The physician's determination is binding and the Contractor may not challenge the determination.

The Contractor shall comply with policies and procedures set forth the IHCP Provider Bulletin regarding Emergency Room Services Coverage dated May 21, 2009 (BT200913), and any updates thereto. If a prudent layperson review determines the service was not an emergency, the Contractor must reimburse for physician services billed on a CMS-1500 claim, in accordance with the IHCP Provider Bulletin. The Contractor must reimburse for facility charges billed on a UB-04 in accordance with the IHCP Provider Bulletin, if a prudent layperson review determines the service was not an emergency. A copy of IHCP Provider Bulletin #BT200913 is included in the Bidder's Library.

The Contractor must demonstrate to OMPP that it has the following mechanisms in place to facilitate payment for emergency services and manage emergency room utilization:

- A mechanism in place for a plan provider or Contractor representative to respond within one hour to all emergency room providers twenty four (24)-hours-a-day, seven (7)-days-a-week. The Contractor will be financially responsible for the post-stabilization services if the Contractor fails to respond to a call from an emergency room provider within one hour.

- A mechanism to track the emergency services notification to the Contractor (by the emergency room provider, hospital, fiscal agent or member's PMP) of a member's presentation for emergency services.

- A mechanism to document a member's PMP's referral to the emergency room and pay claims accordingly.

5.6.1 Post-stabilization

As described in 42 CFR 438.114(e) and IC 12-15-12, the Contractor must cover post-stabilization services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or to improve or resolve the member's condition. The Contractor must demonstrate to OMPP that it has a mechanism in place to be available to all emergency room providers twenty four (24)-hours-a-day, seven (7)-days-a-week to respond within one hour to an emergency room provider's request for authorization of continued treatment after the Contractor's member has been stabilized and the emergency room provider believes continued treatment is necessary to maintain stabilization.

5.6.2 Emergency Room Services Co-Payment – Hoosier Healthwise

There is no emergency room services co-payment in Hoosier Healthwise.

5.6.3 Emergency Room Services Co-Payment – HIP

This section is for HIP members only.

A co-payment will apply to non-emergency use of an emergency room by HIP members. Providers will collect the co-payment from members, and POWER Account funds cannot be used by the member to pay the co-payment. The Contractor shall include the member's co-payment information on the member's ID card.

Non-caretakers will be subject to a $25 co-payment for all ER visits. The co-payment must be waived or returned if the member is admitted to the hospital on the same day as the visit.

Parents will also be subject to a co-payment for emergency room services, according to the following schedule:

- < 100% FPL - $3

- 100-150% FPL - $6

- 151-200% FPL - 20% of the cost of the services provided during the visit, or $25, whichever is less

The co-payment must be waived or returned if the parent is found to have an emergency condition, as defined in section 1867(e)(1)(A) of the Emergency Medical Treatment and Active Labor Act, or if the person is admitted to the hospital on the same day as the visit.

The member must receive an appropriate medical screening examination under section 1867 of the Emergency Medical Treatment and Active Labor Act.

Assuming a member has an available and accessible alternate non-emergency services provider and a determination has been made that the individual does not have an emergency medical condition, the hospital must inform the member before providing non-emergency services that:

- The hospital may require payment of the co-payment before the service can be provided;
- The hospital provides the name and location of an alternate non-emergency services provider that is actually available and accessible;
- An alternate provider can provide the services without the imposition of the co-payment; and
- The hospital provides a referral to coordinate scheduling of this treatment.

The Contractor shall instruct its provider network of the emergency room services co-payment policy and procedure, such as the hospital's notification responsibilities (outlined above) and the circumstances under which the hospital must waive or return the co-payment.

5.7 Behavioral Health

The Contractor must provide behavioral health services, which include mental health and substance abuse services, according to the requirements in this section. In doing so, the Contractor shall assure that behavioral health services are provided as part of the treatment continuum of care. The Contractor must demonstrate that behavioral health services are integrated with physical care services. The Contractor shall develop protocols to:

- Provide care that addresses the needs of Hoosier Healthwise and HIP members in an integrated way, with attention to the physical health and chronic disease contributions to behavioral health
- Provide a written plan and evidence of ongoing, increased communication between the PMP, the Contractor and the behavioral health care provider
- Coordinate management of utilization of behavioral health care services with Medicaid Rehabilitation Option (MRO) services and services for physical health

5.7.1 Behavioral Health Care Services

The Contractor must provide all medically necessary community-based, partial hospital and inpatient hospital behavioral health services as identified in Attachment E. Contractors must pay CMHCs at no less than:

- The Indiana Medicaid FFS rate for any covered non-MRO service that the CMHC provides to a Hoosier Healthwise member.
- The Medicare rate or 130% of Medicaid FFS for any covered non-MRO service that the CMHC provides to a HIP member.

The Contractor will provide behavioral health services through hospitals, offices, clinics, in homes, at school (Hoosier Healthwise only) and other locations, as permitted under state and federal law. A full continuum of services, including crisis services, as indicated by the behavioral health care needs of members, shall be available to members.

Behavioral health services codes billed in a primary care setting must be reviewed for medical necessity and, if appropriate, shall be paid by the Contractor.

The Contractor must allow members to self-refer to any behavioral health care provider in the Contractor's network without a referral from the PMP or Contractor authorization. Members may also self-refer to any IHCP-enrolled psychiatrist.

The Contractor will contractually mandate that its behavioral health care network providers notify a member's Contractor within five (5) calendar days of the member's visit, and submit information about the treatment plan, the member's diagnosis, medications, etc. Disclosure of mental health records by the provider to the Contractor and to the PMP is permissible under HIPAA and state law (IC 16-39-2-6(a)) without consent of the patient because it is for treatment. However, consent from the patient is necessary for substance abuse records.

The Contractor must develop mechanisms for facilitating communication between behavioral health and physical health providers to ensure the provision of integrated member care, as described below. Incentive programs, case managers, behavioral health profiles, etc. are potential mechanisms to ensure care coordination and the reciprocal exchange of health information between physical and behavioral health providers. The Contractor must require the behavioral health provider to share clinical information directly with the member's PMP.

5.7.2 Behavioral Health Provider Network

OMPP requires Contractors to develop a sufficient network of behavioral health providers to deliver the full range of behavioral health services. The network must include psychiatrists, psychologists, clinical social workers and other licensed behavioral health care providers. In addition, Contractors must provide inpatient care for a full continuum of mental health and substance abuse diagnoses. See Section 7.2.4 for specific behavioral health network requirements. All services covered under the clinic option must be delivered by licensed psychiatrists and HSPPs, or an Advanced Practice Nurse or person holding a master's degree in social work, marital and family therapy or mental health counseling.

The Contractor must train its providers in identifying and treating members with behavioral health disorders, and must train PMPs and specialists on when and how to refer members for behavioral health treatment. The Contractor must also train providers in screening and treating individuals who have co-existing mental health and substance abuse disorders. The Contractor is responsible for ensuring that its behavioral health network providers are trained about and are aware of the cultural diversity of its member population and are competent in respectfully and effectively interacting with individuals with varying racial, ethnic and linguistic differences. The Contractor must provide to OMPP its written training plan, which shall include dates, methods (e.g., seminar, web conference, etc.) and subject matter for training on integration and cultural competency.

Members must be able to receive timely access to medically necessary behavioral health services. The network must meet the access requirements specified in Section 7.2.4.

5.7.3 Case Management for Members Receiving Behavioral Health Services

The Contractor must employ or contract with case managers with training, expertise and experience in providing case management services for members receiving behavioral health services. At a minimum, the Contractor must provide case management services for any member at risk for inpatient psychiatric or substance abuse hospitalization, and for members discharged from an inpatient psychiatric or substance abuse hospitalization, for no fewer than one hundred and eighty (180) calendar days following that inpatient hospitalization. Case managers must contact members during an inpatient hospitalization, or immediately upon receiving notification of a member's inpatient behavioral health hospitalization, and must schedule an outpatient follow-up appointment to occur no later than seven (7) calendar days following the inpatient behavioral health hospitalization discharge.

Case managers should use the results of health screenings and more detailed health assessments to identify members in need of case management services. Case managers must also monitor members receiving behavioral health services who are new to the Contractor's plan to ensure that the member is expediently linked to an appropriate behavioral health provider. The case manager must monitor whether the member is receiving appropriate services and whether the member is at risk of over- or under-utilizing services. OMPP shall provide access to its web-based interface Indiana*AIM* to allow the Contractor to monitor MRO utilization, which is covered by Medicaid FFS.

Case managers must regularly and routinely consult with both the member's physical and behavioral health providers to facilitate the sharing of clinical information, and the development and maintenance of a coordinated physical health and behavioral health treatment plan for the member.

In addition, with the appropriate consent, case managers must notify both PMPs and behavioral health providers when a member is hospitalized or receives emergency treatment for behavioral health issues, including substance abuse. Case managers must provide this notification within five (5) calendar days of the hospital admission or emergency treatment.

Documentation of case management procedures, contacts, interventions and outcomes shall be made available to OMPP upon request.

5.7.4 Behavioral Health Care Coordination

The Contractor must ensure the coordination of physical and behavioral health care among all providers treating the member. The Contractor must coordinate services for individuals with multiple diagnoses of mental illness, substance abuse and physical illness. The Contractor must facilitate reciprocal exchange of health information between physical and behavioral providers treating the member.

OMPP requires that the Contractor share member medical data with physical and behavioral health providers and coordinate care for all members receiving both physical and behavioral health services, to the extent permitted by law and in accordance with the member's consent, when required. Contractors must contractually require every provider contracted with the

Contractor, including behavioral health providers, to ask and encourage members to sign a consent that permits release of substance abuse treatment information to the Contractor and to the PMP or behavioral health provider, if applicable.

Contractors must, on at least a quarterly basis, send a behavioral health profile to the respective PMP. The behavioral health profile lists the physical and behavioral health treatment received by that member during the previous reporting period. Information about substance abuse treatment and HIV/AIDS should only be released if member consent has been obtained.

For each member receiving behavioral health treatment, the Contractor will contractually require behavioral health providers to document and share the following information for that member with the Contractor and PMP:

- A written summary of each member's treatment session
- Primary and secondary diagnoses
- Findings from assessments
- Medication prescribed
- Psychotherapy prescribed
- Any other relevant information

Contractors must, at a minimum, establish referral agreements and liaisons with both contracted and non-contracted CMHCs, and must provide physical health medical information to the appropriate CMHC for every member.

Documentation of integration policies and procedures, contacts, behavioral health profile templates and outcomes data shall be made available to OMPP upon request.

5.7.5 Behavioral Health Continuity of Care

Behavioral health case managers must monitor the care of a member receiving behavioral health services who is new to the Contractor or who is transitioning to another MCO or other treatment provider, to ensure that medical records, treatment plans and other pertinent medical information follows the transitioning member. The behavioral health case manager must notify the receiving MCO or other provider of the member's previous behavioral health treatment, and must offer to provide to the new provider the member's treatment plan, if available, and consultation with the member's previous treating provider. The Contractor and receiving MCO must coordinate information regarding prior authorized services for members in transition.

The Contractor must require, through provider contract provisions, that members receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge. This treatment must be provided within seven (7) calendar days from the date of the member's discharge. If a member misses an outpatient follow-up or continuing treatment, the Contractor must ensure that a behavioral health care provider or the Contractor's behavioral health case manager contacts that member within three (3) business days of the missed appointment.

5.7.6 Partial Hospitalization Services

The State supports the implementation of partial hospitalization programs to provide a continuum of care to either prevent hospitalization or act as a step down service to transition members from inpatient hospitalization to community care. These programs must be highly intensive, time-limited medical services that either provide a transition from inpatient psychiatric hospitalization to community-based care, or serve as a substitute for an inpatient admission. Partial hospitalization programs are highly individualized with treatment goals that are measureable and medically necessary. Treatment goals must include specific timeframes for achievement of goals and treatment goals must be directly related to the reason for admission. To receive partial hospitalization services, members must have a diagnosed or suspected behavioral health condition and one of the following:

(i) Short-term deficit in daily functioning; or

(ii) Assessment of the individual indicates a high probability of serious deterioration of the individual's general medical or behavioral health without structured intervention

The full service description and program requirements for coverage of partial hospitalization services will be found in the Indiana Administrative Code on or before July 1, 2010.

5.8 Disease Management

OMPP seeks to contract with MCOs that have specific experience and demonstrated success operating disease management programs for low income populations. In the Bidder's response to the RFS, the Bidder must indicate how their disease management programs will be adopted for the particular challenges of a low income population, including the need to meet the fifth grade reading level requirements set forth in Section 6.4.

The Contractor must offer, at minimum, asthma, depression, pregnancy, ADHD, autism/pervasive developmental disorder, COPD, coronary artery disease, chronic kidney disease, congestive heart failure and diabetes disease management programs for eligible Hoosier Healthwise and HIP members. Members with excessive utilization or under-utilization for conditions other than those listed shall also be eligible for the disease management services described in this section. Members with these conditions should be identified through the health screening tool described in Section 6.2.3 and by identification of conditions based on claims.

The Contractor must make a spectrum of disease management tools available to the population, including population-based interventions, case management and care management, as described below. All case and care management disease management programs should identify psychosocial issues of the members that may contribute to poor health outcomes and provide appropriate support services for addressing such issues.

The Contractor must submit quarterly reports to OMPP regarding the selection criteria, strategies, outcomes and efficacy of these and any other disease management programs offered by the Contractor. The quarterly reports must include participation rates and utilization and cost statistics of members enrolled in the disease management programs. For example, the diabetes disease management quarterly report will include all members with two or more claims in the calendar year for diabetes, and the numerator shall include those members enrolled in case or care

management as defined below. Separate, mutually exclusive calculations for members in case and care management shall be conducted. The reports must also identify any member at least three (3) standard deviations outside of the mean of utilization of inpatient days, emergency department visits and home health service days for the population group. All disease management programs must encourage compliance with national care guidelines (e.g., American Diabetic Association) and incentivize healthy member behaviors. All members shall be sent population-based disease management materials (e.g., educational fliers, screening reminders, etc.). OMPP believes that the Contractor's disease management programs will serve as a critical area for pursuing continuous innovation in improving member health status, and disease management programs may be subject to onsite visits or external quality reviews.

OMPP reserves the right to require the Contractor to have disease management programs for additional conditions in the future. OMPP will provide three (3) months advance notice to the Contractor if OMPP decides to add new diseases to the disease management program requirements.

The Contractor is encouraged to offer additional disease management programs beyond those required in the Scope of Work. If the Contractor provides additional disease management programs, the Contractor must also provide annual updates to OMPP documenting the strategies, outcomes and efficacy of the additional disease management programs.

OMPP reserves the right to examine the Contractor's disease management programs at any time, including during the proposal review process, prior to Contract execution, during the readiness review and during the term of the Contract.

Disease management consists of three levels of Contractor-member interaction, including population-based interventions, case management and care management.

5.8.1 Population-Based Interventions

The Contractor shall engage members with the conditions of interest or the parents of children with conditions of interest through disease specific and preventive care population-based interventions including educational materials and appointment and preventive care reminders. All pregnant members shall receive standard pregnancy care educational materials, OMPP-approved tobacco cessation materials and access information for 24-Hour Nurse Call Lines. Any given member may be eligible for more than one condition. Materials should be delivered through postal and electronic direct-to-consumer contacts, as well as web-based education materials inclusive of clinical practice guidelines. Materials shall be developed at the fifth grade reading level. All members with the conditions of interest must receive materials no less than bi-annually. The Contractor must document the number of persons with conditions of interest, mailings and website hits.

5.8.2 Case Management

The Contractor's protocol for referring members to case management shall be reviewed by OMPP and must be based on identification through the health screening or when the claims history suggests need for intervention. In addition to population-based disease management educational materials and reminders, these members should receive more intensive services. Members with newly diagnosed conditions, increasing health services or emergency services utilization, evidence of pharmacy non-compliance for chronic conditions and identification of

special health care needs should be strongly considered for case management. Case management services include direct consumer contacts in order to assist members with scheduling, location of specialists and specialty services, transportation needs, 24-Hour Nurse Line, general preventive (e.g. mammography) and disease specific reminders (e.g. Hgb A1C), pharmacy refill reminders, tobacco cessation and education regarding use of primary care and emergency services.

The Contractor must make every effort to contact members in case management telephonically. Materials should also be delivered through postal and electronic direct-to-consumer contacts, as well as web-based education materials inclusive of clinical practice guidelines. Materials shall be developed at the fifth grade reading level. All members with the conditions of interest must receive materials no less than quarterly. The Contractor must document the number of persons with conditions of interest, outbound telephone calls, telephone contacts, category of intervention, intervention delivered, mailings and website hits. Case management shall be coordinated with the Right Choices Program for members qualifying for the Right Choices Program. However, the Right Choices Program is not a replacement for case management.

5.8.3 Care Management

The Contractor's protocol for referring members to care management shall be reviewed by OMPP and must be based on identification through the health screening as having special care needs, a condition of interest named above and/or a chronic or co-morbid disease utilization history that indicates the need for real-time, proactive intervention. Persons with clinical medical training shall be required to develop the member's care plan, and care plans shall be reviewed by the Medical Director. Care plans developed by the Contractor must include clearly stated health care goals, defined milestones to document progress, clearly defined accountability and responsibility and timely, thorough review with appropriate corrections ("course changes") as indicated. The Contractor's care management services must involve the active management of the member and his/her group of health care providers, including physicians, medical equipment, transportation and pharmacy. The member's health care providers must be included in the development and execution of member care plans. Care plans and care management must take into account co-morbidities being jointly managed and executed, as separate care plans for each medical problem in the same member may fragment care and add to the potential of missing interactive factors.

The Contractor must contact members telephonically and in-person as indicated by their need. Care managers should engage in care conferences with the member's health care providers, as necessary. Members shall receive the same educational materials delivered to those persons receiving case management including direct consumer contacts in order to assist members with scheduling, location of specialists and specialty services, transportation needs, 24-Hour Nurse Call Line, general preventive (e.g. mammography) and disease specific reminders (e.g. Hgb A1C), pharmacy refill reminders, tobacco cessation and education regarding use of primary care and emergency services. Materials can be delivered through postal and electronic direct-to-consumer contacts, as well as web-based education materials inclusive of clinical practice guidelines. Materials shall be developed at the fifth grade reading level. The Contractor must document the number of persons with conditions of interest, outbound telephone calls to providers and members, telephone contacts to members and providers, category of intervention, intervention delivered, mailings and website hits.

Utilization statistics on hospitalizations, emergency services, primary care and specialty care should be documented and trended from baseline. The Contractor's care management services must be coordinated with the Right Choices Program for members qualifying for the Right Choices Program. However, the Right Choices Program shall not be considered a replacement for care management.

5.9 24-hour Nurse Call Line

The Contractor shall provide nurse triage telephone services for members to receive medical advice twenty-four (24) hours-a-day/seven (7)-days-a-week from trained medical professionals. The twenty four (24)-hour Nurse Call Line should be well publicized and designed as a resource to members to help discourage inappropriate emergency room use, particularly for members in disease management. The 24-hour Nurse Call Line must have a system in place to communicate all issues with the member's PCP.

5.10 Other Covered Benefits and Services

In addition to the benefits and services listed above, the Contractor must also cover the following:

- For its Hoosier Healthwise and HIP members, the Contractor must cover **diabetes self-management services** when the member obtains the services from IHCP self-referral providers. However, IC 27-8-14.5-6 also provides that coverage for diabetes self-management is subject to the requirements of the insurance plan (i.e., Contractor) when a member seeks diabetes self-management services from providers other than providers designated as IHCP self-referral providers. The statute also recognizes that eye care and podiatry, which may include diabetes self-management services, are self-referral services. The Contractor may direct its members to providers in the Contractor's network for diabetes self-management services. However, the Contractor must cover diabetes self-management services if the member chooses an IHCP self-referral provider outside the Contractor's network.

- For its Hoosier Healthwise members, the Contractor shall provide **prenatal care programs** targeted to avert untoward outcomes in high-risk pregnancies.

- For its Hoosier Healthwise members, the Contractor shall provide **newborn health care and parenting education.**

- For its HIP members, the Contractor must provide, at a minimum, a **$500 Preventive Care Benefit**. HIP is designed to facilitate access to, and emphasize the importance of, preventive care. Covered HIP benefits include $500 of "first dollar" coverage for preventive care services. Such services are not subject to the deductible and no cost-sharing applies. Members can use the $500 preventive care benefit to cover routine preventive services such as mammograms, colorectal screenings, smoking cessation classes, etc. Each year, OMPP will identify which preventive services will be covered in the $500 of "first dollar" coverage. Members can receive additional preventive services beyond the $500 threshold, but these services will be subject to the deductible unless the Contractor elects to provide a Preventive Care Benefit that is in excess of $500. "Preventive care services" means care that is provided to an individual to prevent disease, diagnose disease or promote good health.

5.11 Carved-out Services

Some services are not included in the Contractor's capitation rates for the Hoosier Healthwise or HIP populations and, therefore, are not the responsibility of the Contractor. These services are referred to as "carved-out" services. The State fiscal agent pays on a FFS basis for carved-out services rendered to the Contractor's members. However, under some circumstances, services related to the carved-out services are the responsibility of the Contractor for reimbursement.

Listed below are the carved-out services in the Hoosier Healthwise and HIP programs and the conditions under which related services are the Contractor's responsibility. The Managed Care Policies and Procedures Manual describes these carved-out services in greater detail.

- Medicaid Rehabilitation Option (MRO) services (Hoosier Healthwise) are not the Contractor's responsibility. The Contractor is responsible for care coordination, as described in Section 5.7, with physical and other behavioral health services for individuals receiving MRO services. See Attachment E for specific codes for MRO services.

- Dental services (Hoosier Healthwise) rendered by providers enrolled in the IHCP as providers in a dental specialty are not the Contractor's responsibility; however, some associated services related to dental surgery (e.g., anesthesia, post-operative services, transportation) may be the Contractor's responsibility. The Contractor is also responsible for helping members access the dental benefit and locate dental providers. The dental specialties are:

    - Endodontists
    - General dentistry practitioners
    - Oral surgeons
    - Orthodontists
    - Pediatric dentists
    - Periodontists
    - Pedodontists
    - Prosthodontists

- Individualized Family Services Plan (IFSP) services (Hoosier Healthwise) provided under the FSSA FirstSteps program. The Contractor should provide case management to these special needs children.

- Individualized Education Plan (IEP) services (Hoosier Healthwise) provided by a school are carved-out from the Contractor's responsibility. The Contractor should

communicate and coordinate with the school to ensure continuity of care and avoid duplication of services.

- Pharmacy services (Hoosier Healthwise and HIP) identified in Section 5.4 are not the responsibility of the Contractor and are covered by Indiana Medicaid FFS under the pharmacy benefit consolidation.

5.12 Excluded Services

The Hoosier Healthwise and HIP programs exclude some benefits from coverage under managed care. These excluded benefits are available under traditional Medicaid or other waiver programs and include long-term care, home- and community-based waiver services (HCBS) and hospice services. Therefore, a member who is, or will be, receiving excluded services (e.g., long-term care, home- and community-based waiver and hospice services) must be disenrolled from managed care in order to be eligible for the services. The Contractor is responsible for the member's care until the member is disenrolled from the plan unless stated otherwise. The Managed Care Policies and Procedures Manual describe member disenrollment in greater detail.

Excluded services are:

- Long-term institutional care: Package A members and HIP members requiring long-term care in a nursing facility or Intermediate Care Facility for the Mentally Retarded (ICF/MR) must be disenrolled from the Hoosier Healthwise or HIP program and converted to fee-for-service eligibility in the IHCP. Before the nursing facility can be reimbursed by IHCP for the care provided, the nursing facility must request a Pre-Admission Screening Resident Review (PASRR) for nursing facility placement. The State must then approve the PASRR request, designate the appropriate level of care in Indiana*AIM* and disenroll the member from Hoosier Healthwise or HIP. The Contractor must coordinate care for its members that are transitioning into long-term care by working with the facility to ensure timely submission of the request for a PASRR, as described in the IHCP Provider Manual. The Contractor is responsible for payment for up to sixty (60) calendar days for its members placed in a long-term care facility while the level of care determination is pending.

  However, the Contractor may obtain services for its members in a nursing facility setting on a short-term basis, i.e., for fewer than thirty (30) calendar days. This may occur if this setting is more cost-effective than other options and the member can obtain the care and services needed in the nursing facility. The Contractor may negotiate rates for reimbursing the nursing facilities for these short-term stays.

- Hospice (Hoosier Healthwise only): Hospice care is not covered under the Hoosier Healthwise program; however, terminally ill members may qualify for hospice care under the fee-for-service Medicaid program once they are disenrolled from Hoosier Healthwise. The hospice provider can submit a hospice election form for the member to the IHCP Prior Authorization Unit. The IHCP Prior Authorization Unit will then initiate the disenrollment of the member from managed care and facilitate hospice coverage. The Contractor must coordinate care for its members that are transitioning into hospice by providing to an IHCP hospice provider any information required to complete the hospice

election form for the Contractor's terminally ill members desiring hospice, as described in the IHCP Hospice Provider Manual.

- Home- and community-based services (HCBS) waiver: Home- and community-based waiver services are also excluded from the Hoosier Healthwise and HIP programs. Similar to the situations described above, members who have been approved for these waiver services must be disenrolled from managed care and the Contractor must coordinate care for its members that are transitioning into a HCBS waiver program until the disenrollment from Hoosier Healthwise or HIP is effective.

- Psychiatric treatment in a state hospital: Hoosier Healthwise members receiving psychiatric treatment in a state hospital will be disenrolled from Hoosier Healthwise. HIP members receiving psychiatric treatment in a state hospital shall not be disenrolled from HIP, but should be directed to an alternative inpatient facility.

- Psychiatric Residential Treatment Facility (PRTF) Services (Hoosier Healthwise only): Members receiving treatment in a psychiatric residential treatment facility (PRTF) are not the Contractor's responsibility and will be disenrolled from Hoosier Healthwise.

- Pregnancy Services (HIP only): HIP excludes pregnancy and related services from its covered services. When a member becomes pregnant, the Contractor must help her enroll in Hoosier Healthwise in order to receive coverage for pregnancy and related services. The woman may be re-enrolled in HIP, providing she remains eligible, after her pregnancy has ended.

  Contractor must have policies and procedures in place for identifying pregnant members and helping them enroll in Hoosier Healthwise. These policies and procedures must establish that the Contractor will inform both the member and the provider of the procedure to get enrolled in Hoosier Healthwise and also provide the necessary forms to enroll in Hoosier Healthwise. The Contractor must also have a process for identifying members in their eligibility and claims system to make sure they have successfully obtained Hoosier Healthwise coverage. Once a woman is enrolled in Hoosier Healthwise, she will be disenrolled from HIP but will remain in the Contractor's plan unless the Contractor's provider network does not provide sufficient access to OB/GYNs.

  The Contractor's liability for covering a HIP pregnant member continues under Hoosier Healthwise throughout the pregnancy and plus sixty (60) calendar days postpartum. The Contractor must advise providers that all pregnancy-related claims incurred during the pregnancy discovery period (up to three (3) months) (based on date of service) will be reimbursed under Hoosier Healthwise once Hoosier Healthwise coverage has been approved. In addition the Contractor must 1) provide a written explanation to providers for any claims determination made during the member's HIP coverage that informs them that consideration will be made for the claim upon the member's transfer to Hoosier Healthwise; 2) assist members in obtaining and submitting proof of pregnancy to the State per current Hoosier Healthwise requirements; 3) assure providers are given access to the Medicaid RID number for the member; and 4) complete any other responsibilities that may be required to initiate the transfer of a pregnant member to Hoosier Healthwise.

Contractors must inform members, in writing, that in order to receive coverage for their pregnancy, they must switch coverage to Hoosier Healthwise. The Contractor will inform members that in order to qualify for Hoosier Healthwise pregnancy coverage, verification of pregnancy must be provided to DFR.

The Contractor will facilitate getting the required documentation or the member can take care of it herself. Pregnant members can call the DFR Service Center (or other office as specified by the State) to report the pregnancy. DFR may then send her the change report form that she can attach to her doctor's statement or she can be given the Document Center's address to mail or fax the doctor's statement. DFR will then close the HIP case and approve Hoosier Healthwise.

A member shall not be transferred out of HIP if the first pregnancy-related claim incurred is for spontaneous abortion or any expense related to a termination of pregnancy. In this situation, the member shall remain enrolled in HIP and the Contractor shall pay for this expense. Therefore, the State is defining pregnancy-related claims as those indicative of active pregnancies and/or deliveries of a living fetus.

Additional guidelines regarding the Contractor's responsibility to help pregnant members obtain Hoosier Healthwise coverage are located in the Managed Care Policies and Procedures Manual.

5.13 Continuity of Care

OMPP is committed to providing continuity of care for members as they transition between various IHCP programs. The Contractor must have mechanisms in place to ensure the continuity of care and coordination of medically necessary health care services for its Hoosier Healthwise and HIP members. The State emphasizes several critically important areas where the Contractor must address continuity of care. Critical continuity of care areas include, but are not limited to:

- Transitions for members receiving behavioral health services, especially for those members who have received prior authorization from their previous MCO or through fee-for-service
- A member's transition into the Hoosier Healthwise or HIP program from traditional fee-for-service
- A member's transition between MCOs, particularly during an inpatient stay
- A member's transition between IHCP programs, particularly when a HIP member becomes pregnant or disabled or meets the annual or lifetime benefit maximum
- A HIP member's transition to or from the ESP
- Members exiting the Hoosier Healthwise or HIP program to receive excluded services
- A HIP member's transition to private insurance
- A member's transition to no coverage

In situations such as a member or PMP disenrollment, the Contractor must facilitate care coordination with other MCOs or other PMPs. When receiving members from another MCO or fee-for-service, the Contractor must honor the previous care authorizations for a minimum of thirty (30) calendar days. The Contractor must establish policies and procedures for identifying outstanding prior authorization decisions at the time of the member's enrollment in their plan.

The Contractor will be responsible for care coordination after the member has disenrolled from the Contractor whenever the member disenrollment occurs during an inpatient stay. In these cases, the Contractor will remain financially responsible for the hospital DRG payment and any outlier payments (without a capitation payment) until the member is discharged from the hospital or the member's eligibility in Medicaid terminates. The Contractor must coordinate discharge plans with the member's new MCO.

See Section 5.7 for additional requirements regarding continuity of care for behavioral health services. The Managed Care Policies and Procedures Manual describes the Contractor's continuity and coordination of care responsibilities in more detail.

5.13.1 Special Pregnancy Provisions – Hoosier Healthwise

When a Hoosier Healthwise woman enrolls with a Contractor in her third trimester of pregnancy, the Contractor must reimburse for and honor the woman's request to continue to receive maternity care from her current physician.

5.14 Out-of-Network Services

With the exception of certain self-referral service providers and emergency medical care, the Contractor may limit its coverage to services provided by in-network providers once the Contractor has met the network access standards set forth in Section 7. However, in accordance with 42 CFR 438.206(b)(4), the Contractor must authorize and pay for out-of-network care if the Contractor is unable to provide necessary covered medical services within sixty (60)-miles of the member's residence by the Contractor's provider network. The Contractor must authorize these out-of-network services in the timeframes established in Section 8.3.2 and must adequately cover the services for as long as the Contractor is unable to provide the covered services in-network. The Contractor must require out-of-network providers to coordinate with the Contractor with respect to payment and ensure that the cost to the member is no greater than it would be if the services were furnished in-network.

The Contractor may require providers not contracted in the Contractor's network to obtain prior authorization from the Contractor to render any non-self-referral or non-emergent services to Contractor members. If the out-of-network provider has not obtained such prior authorization, the Contractor may deny payment to that out-of-network provider. The Contractor must cover and reimburse for all authorized, routine care provided to its members by out-of-network providers.

Contractors must make nurse practitioner services available to members. Members must be allowed to use the services of nurse practitioners out-of-network if no nurse practitioner is available in the member's service area within the Contractor's network. If nurse practitioner services are available through the Contractor, the Contractor must inform the member that nurse practitioner services are available.

In HIP, Contractors must make covered services provided by FQHCs and RHCs available to members out-of-network if an FQHC or RHC is not available in the member's service area within the Contractor's network.

The Contractor may not require an out-of-network provider to acquire a Contractor-assigned provider number for reimbursement. An NPI number shall be sufficient for out-of-network provider reimbursement.

5.14.1 Out-of-Network Provider Reimbursement – Hoosier Healthwise

The Contractor must reimburse any out-of-network provider's claim for authorized services provided to Hoosier Healthwise members at a rate it negotiates with the out-of-network provider, or the lesser of the following:

- The usual and customary charge made to the general public by the provider; or
- The established Indiana Medicaid FFS reimbursement rates that exist for participating IHCP providers at the time the service was rendered.

5.14.2 Out-of-Network Provider Reimbursement – HIP

The Contractor must reimburse any out-of-network provider's claim for authorized services provided to HIP members at the Medicare rate or, if the service does not have a Medicare rate, 130% of the Medicaid rate for that service.

5.15 Enhanced Services

The State encourages the Contractor to cover programs that enhance the general health and well being of its Hoosier Healthwise and HIP members, including programs that address preventive health, risk factors or personal responsibility. These enhanced programs and services are above and beyond those covered in the Hoosier Healthwise and HIP programs.

All enhanced services must comply with the member incentives guidelines set forth in Section 8.2.2 and other relevant state and federal rules regarding inducements. The Contractor shall notify OMPP prior to initiating such services.

Enhanced services may include, but are not limited to, such items as:

- Enhanced transportation arrangements for members. Examples include transportation to obtain pharmacy services, attend member education workshops on nutrition, healthy living, parenting, prenatal classes, etc.

- Disease management programs or incentives beyond those required by the State

- Healthy lifestyles incentives

- Group visits with nurse educators and other patients

5.16 Annual and Lifetime Benefit Cap – HIP

HIP members are subject to a $300,000 annual benefits cap and a $1,000,000 lifetime benefits cap. The Contractor must notify the member when he or she approaches the annual and lifetime coverage limits. When the member has utilized $100,000 and $200,000 of coverage within an annual benefit period or $900,000 of lifetime coverage, the Contractor must inform the member and provide relevant information regarding other ongoing coverage sources such as ICHIA, M.E.D. Works and Medicaid. The Contractor must send separate notices for the $100,000 level, the $200,000 level and the $900,000 level.

When the member has reached the annual and lifetime benefit limits, the Contractor must inform the member and again provide relevant information regarding other ongoing coverage sources. The Contractor must notify the State when a member reaches their lifetime coverage limit. A member who reaches the lifetime limit will be disenrolled from HIP permanently. When a member reaches the annual limit, the member must continue to make their POWER Account contributions in order to remain eligible in the following annual benefit period, although no services will be covered in the remainder of the current benefit period. The Contractor must continue to provide monthly invoices and monthly POWER Account statements to maintain active member participation and awareness that coverage will be reinstated in the new benefit period.

The Contractor shall provide monthly updates regarding the member's annual and lifetime claims activity to the State fiscal agent via the PRF, which is an electronic transaction. See the Bidder's Library for further information regarding the reporting requirements for the lifetime and annual maximum information. POWER Account technical requirements, including the PRF, are in the process of being updated and shall be released in 2010. The Contractor shall be required to comply with these requirements as of the effective date of the Contract.

6.0 Member Services

6.1 Marketing and Outreach

OMPP encourages Contractors to promote its plans as a solution for the entire family and should include information about both programs in its marketing and outreach activities. All promotional efforts must jointly market the Contractor's Hoosier Healthwise and HIP products and services. All marketing efforts must be targeted to the general community in the Contractor's entire service area. In accordance with 42 CFR 438.104, the Contractor cannot conduct, directly or indirectly, door-to-door, telephone or other "cold-call" marketing enrollment practices. Cold-call marketing is defined in 42 CFR 438.104 as any unsolicited personal contact by the Contractor with a potential Medicaid enrollee. Additionally, the Contractor must not distribute any marketing materials without first obtaining OMPP approval.

The Contractor may market by mail, mass media advertising (e.g., radio and television) and community-oriented marketing directed at potential members. The Contractor must conduct marketing and advertising in a geographically balanced manner, paying special attention to rural areas of the State. The Contractor must provide information to potential eligible individuals who live in medically underserved rural areas of the State. Marketing materials should include the requirements and benefits of the Contractor's health plans, as well as the Contractor's provider network.

The Contractor may offer to potential members tokens or gifts of nominal value, so long as the Contractor acts in compliance with all marketing provisions provided for in 42 CFR 438.104, and other federal and state regulations and guidance regarding inducements in the Medicare and Medicaid programs.

The Contractor must submit to OMPP an annual marketing plan. The annual marketing plan is due within sixty (60) calendar days of the beginning of each calendar year. All member marketing and outreach materials must be submitted to OMPP for approval prior to distribution according to the timeframes set forth in Section 6.5.

Any outreach and marketing activities (written and oral) must be presented and conducted in an easily understood manner and format, at a fifth grade reading level, and must not be misleading or designed to confuse or defraud. Examples of false or misleading statements include, but are not limited to:

- Any assertion or statement that the member or potential member must enroll in the Contractor's health plan to obtain benefits or to avoid losing benefits
- Any assertion or statement that the Contractor is endorsed by CMS, the federal or state government or a similar entity
- Any assertion or statement that the Contractor's health plan is the only opportunity to obtain benefits under the Hoosier Healthwise or HIP programs

The Contractor cannot entice a potential member to join its health plan by offering any other type of insurance as a bonus for enrollment, and the Contractor must ensure that a potential member can make his/her own decision as to whether or not to enroll. Marketing materials and plans shall be designed to reach a distribution of potential members across age and sex categories. Potential members may not be discriminated against on the basis of health status or need for health care services, or on any other basis inconsistent with state or federal law.

The Contractor may distribute or mail an informational brochure or flyer to potential members and/or provide (at its own cost, including any costs related to mailing) such brochures or flyers to the State for distribution to individuals that apply for the Hoosier Healthwise and HIP programs through the State.

The Contractor may submit promotional poster-sized wall graphics to OMPP for approval. If approved, the Contractor can make these posters available to the local DFR offices and other enrollment centers for display in an area where application and MCO selection occurs. The local DFR offices and enrollment centers may display these promotional materials at their discretion. The Contractor may display these same promotional materials at community health fairs or other outreach locations. OMPP must pre-approve all promotional and informational brochures or flyers and all graphics prior to display or distribution.

6.2 Member Enrollment

Applicants for both the Hoosier Healthwise and HIP programs will have an opportunity to select an MCO on their application. MCOs are expected to conduct marketing and outreach efforts to raise awareness of both the programs and their product. The Enrollment Broker is available to

assist members in choosing an MCO. Applicants who do not select an MCO on their application will be auto-assigned to an MCO according to the State's auto-assignment methodology.

6.2.1 New Member Materials

Within five (5) calendar days of a new member's enrollment, the Contractor shall send the new member a Welcome Packet. The Welcome Packet shall include, but not be limited to, a new member letter, explanation of where to find information about the Contractor's provider network and a copy of the member handbook. A description of the member handbook is provided in Section 6.4.1 below. For HIP members, the Welcome Packet must also include a member ID card and POWER Account debit card. The same card may serve as both the member ID card and POWER Account debit card. The member ID card must include the member's RID number and the applicable emergency services co-payment amount.

The Welcome Packet should also include information about selecting a PMP, completing a health screening and any unique features of the Contractor. For example, if the Contractor incentivizes members to complete a health screening, a description of the member incentive should be included in the Welcome Packet. For HIP members, the Welcome Packet must also include educational materials about the POWER Account and POWER Account roll over, as well as the recommended preventive care services for the member's benefit year.

6.2.2 PMP Selection

The Contractor must assure that each member has a PMP who is responsible for providing an ongoing source of primary care appropriate to the member's needs. Following a member's enrollment, the Contractor must assist the member in choosing a PMP. Unless the member elects otherwise, the member must be assigned to a PMP within thirty (30) miles of the member's residence.

The Contractor must document at least three (3) telephone contacts made to assist the member in choosing a PMP. If the member has not selected a PMP within thirty (30) calendar days of the member's enrollment, the Contractor shall assign the member to a PMP. The member must be assigned to a PMP within thirty (30) miles of the member's residence, and the Contractor should consider any prior provider relationships when making the assignment. OMPP must approve the Contractor's PMP auto-assignment process prior to implementation, and the process must comply with any guidelines set forth by OMPP. See the Managed Care Policies and Procedures Manual for further detail.

Providers that may serve as PMPs include internal medicine physicians, general practitioners, family medicine physicians, pediatricians, obstetricians (Hoosier Healthwise only), gynecologists and endocrinologists (if primarily engaged in internal medicine).

6.2.3 Health Screening

Beginning February 1, 2011, the Contractor shall conduct a health screening for new members that enroll in the Contractor's plan. The health screening will be used to identify the member's physical and/or behavioral health care needs, special health care needs, as well as the need for disease management, case management and/or care management services set forth in Section 5.8. The health screening may be conducted in person, by phone, online or by mail. The Contractor must use the standard health screening tool developed by OMPP,

i.e., the Health Risk Screener (HRS), but is permitted to supplement the OMPP health screening tool with additional questions developed by the Contractor. Any additions to the OMPP health screening tool must be approved by OMPP. For pregnant Hoosier Healthwise members, a completed Notification of Pregnancy (NOP) form fulfills the health screening requirement.

The health screening must be conducted within ninety (90) calendar days of a new member's enrollment in the Contractor's plan. The Contractor is encouraged to conduct the health screening at the same time it assists the member in making a PMP selection. The Contractor shall also be required to conduct a subsequent health screening if a member's health care status is determined to have changed since the original screening, such as evidence of overutilization of health care services as identified through such methods as claims review. Non-clinical staff may conduct the health screening. The results of the health screening must be transferred to OMPP in the form and manner set forth by OMPP.

The Contractor shall not be required to conduct health screenings for members enrolled in the Contractor's plan prior to February 1, 2011 unless a change in the member's health care status indicates the need to conduct a health screening. For purposes of the health screening requirement, new members are defined as members that have not been enrolled in the Contractor's plan in the previous twelve (12) months.

Data from the health screening or NOP form, current medications and self-reported medical conditions will be used to develop stratification levels for members in Hoosier Healthwise and HIP. While the Contractor may use its own proprietary stratification methodology to determine which members should be referred to specific disease management programs, ranging from member detailing to care management, OMPP shall apply its own stratification methodology which may, in future years, be used to link stratification level to the per member per month capitation rate.

The initial health screening shall be followed by a detailed Health Assessment by a health care professional when a member is identified through the screening as having a special health care need, as set forth in Section 6.2.4, or when there is a need to follow up on problem areas found in the initial health screening. The detailed Health Assessment may include, but is not limited to, discussion with the member, a review of the member's claims history and/or contact with the member's family or health care providers. These interactions must be documented and shall be available for review by OMPP.

The Contractor must keep up-to-date records of those members found to have special health care needs based on the initial screening, including documentation of the follow-up detailed Health Assessment and contacts with the member, their family or health care providers.

6.2.4 Children with Special Health Care Needs

The Contractor must have plans for provision of care for the special needs populations and for provision of medically necessary, specialty care through direct access to specialists. The Hoosier Healthwise managed care program uses the definition and reference for children with special health care needs as adopted by the Maternal and Child Health Bureau (MCHB) and published by the American Academy of Pediatrics (AAP):

> "Children with special health care needs are those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally."

The health screening tool will assign children to one of the Living with Illness Measures (LWIM) screener health domains based on the National Committee on Quality Assurance study design. The scoring for the LWIM screener identifies a child as potentially having a special health care need if the screening identifies needs in one or more of seven (7) different health domains:

- Functional limitations only
- Dependency on devices only
- Service use or need only
- Functional limitations and a dependency on devices
- Functional limitations and a service use or need
- Dependency on devices and a service use or need
- Functional limitations, a dependency on devices and a service use or need

In accordance with 42 CFR 438.208(c)(2), the Contractor must have a *health care professional* assess the member through a detailed health assessment if the health screening identifies the member as potentially having a special health care need. When the further assessment confirms the special health care need, the member must be placed in care management. The Contractor must offer continued coordinated care services to any special health care needs members transferring into the Contractor's membership from another MCO. For example, Contractor activities supporting special health care needs populations must include, but are not limited to:

- Conducting the initial screening and more detailed health assessment to identify members who may have special needs
- Scoring the initial screening and more detailed health assessment results
- Distributing findings from the health assessment to the member's PMP, OMPP and other appropriate parties in accordance with state and federal confidentiality regulations
- Coordinating care through a Special Needs Unit or comparable program services in accordance with the member's care plan
- Analyzing, tracking and reporting to OMPP the issues related to children with special health care needs, including grievances and appeals data
- Participating in clinical studies of special health care needs as directed by the State

6.2.5 Member Disenrollment from MCO

In accordance with 42 CFR 438.6(k), and with the exception of permissible referrals to the ESP, the Contractor may neither terminate enrollment nor encourage a member to disenroll because of a member's health care needs or a change in a member's health care status. A

member's health care utilization patterns may not serve as the basis for disenrollment from the Contractor.

The Contractor must notify the local county DFR office, in the manner outlined in the Managed Care Policies and Procedures Manual, within thirty (30) calendar days of the date it becomes aware of the death of one of its members, giving the member's full name, address, Social Security Number, member identification number and date of death. The Contractor will have no authority to pursue recovery against the estate of a deceased Medicaid member.

Additional information about the member disenrollment process is provided in Attachment F and the Managed Care Policies and Procedures Manual.

6.3 Member-Contractor Communications

6.3.1 Member Services Helpline

The Contractor must maintain a statewide toll-free telephone helpline for members with questions, concerns, complaints and requests for PMP changes. The same helpline must be available to Hoosier Healthwise and HIP members, so that members may call one number to answer all the family's questions. Member helpline staff must be equipped to provide customer service to individuals assigned to the Contractor's plan who have not yet made their first POWER Account contribution or Hoosier Healthwise Package C (CHIP) premium payment.

The Contractor must staff the member services helpline to provide sufficient "live voice" access to its members during, at a minimum, a twelve (12)-hour business day, from 7 a.m. to 7 p.m. Eastern, Monday through Friday. The member helpline may be closed on the following holidays:

- New Year's Day
- Memorial Day
- Independence Day (July 4th)
- Labor Day
- Thanksgiving
- Christmas

The Contractor may request that additional days, such as the day before Thanksgiving, be authorized for limited staff attendance. This request must be submitted to OMPP at least thirty (30) calendar days in advance of the date being requested for limited staff attendance and must be approved by OMPP. For all days with a closure, early closing or limited staff attendance, members must have access to the 24 Hour Nurse Call Line as appropriate. Call center closures, limited staffing or early closures shall not burden a member's access to care.

The member services helpline must offer language translation services for members whose primary language is not English and must offer automated telephone menu options in English

and Spanish. A member services messaging option must be available after business hours in English and Spanish and member services staff must respond to all member messages by the end of the next business day. The Contractor must provide Telecommunications Device for the Deaf (TDD) services for hearing impaired members.

Member services helpline staff must be trained in both the Hoosier Healthwise and HIP programs to ensure that member questions and concerns are resolved as expeditiously as possible. The Contractor must have the ability to warm transfer members to outside entities including the Enrollment Broker, the Division of Family Resources (DFR) and provider offices. The Contractor must maintain a system for tracking and reporting the number and type of members' calls and inquiries it receives during business hours and non-business hours. The Contractor must monitor its member services helpline service and report its telephone service level performance to OMPP in the timeframes and specifications described in the Contractor Reporting Manual, which shall be provided following the Contract award date.

The Contractor's member services helpline staff must be prepared to efficiently respond to member concerns or issues including, but not limited to the following:

- Access to health care services
- Identification or explanation of covered services
- Special health care needs
- Procedures for submitting a member grievance or appeal
- Potential fraud or abuse
- Changing PMPs
- POWER Accounts, POWER Account balances and POWER Account debit cards (HIP only)
- POWER Account contributions and Hoosier Healthwise Package C (CHIP) premiums, including initial payments due
- Incentive programs
- Disease management services
- Recommended age and sex appropriate preventive services (HIP only)
- Transfer to Hoosier Healthwise for pregnant women (HIP only)
- Employer contributions (HIP only)
- Balance billing issues

Upon a member's enrollment in the Contractor, the Contractor must inform the member about the member services helpline. The Contractor should encourage its members to call the member services helpline as the first resource for answers to questions or concerns about Hoosier Healthwise, HIP, PMP issues, benefits, Contractor policies, etc.

6.3.2 Electronic Communications

The Contractor shall provide an opportunity for members to submit questions or concerns electronically, via e-mail and through the member website. If a member e-mail address is required to submit questions or concerns electronically to the Contractor, the Contractor shall help the member establish a free e-mail account.

RFS #10-40
ATTACHMENT D
CONTRACTOR SCOPE OF WORK

The Contractor shall respond to questions and concerns submitted by members electronically within twenty-four (24) hours. If the Contractor is unable to answer or resolve the member's question or concern within twenty-four (24) hours, the Contractor must notify the member that additional time will be required and identify when a response will be provided. A final response must be provided within three (3) business days.

The Contractor shall maintain the capability to report on e-mail communications received and responded to, such as total volume and response times. The Contractor shall be prepared to provide this information to OMPP upon request.

6.4 Member Information, Outreach and Education

The Contractor must provide the information listed under this section within a reasonable timeframe, following the notification from the State fiscal agent of the member's enrollment in the Contractor. This information must be included in the member handbook. In addition, the Contractor must notify members at least once a year of their right to request and obtain the information listed in this section. If the Contractor makes significant changes to the information provided under this section, the Contractor must notify the member in writing of the intended change at least thirty (30) calendar days prior to the intended effective date of the change, in accordance with 42 CFR 438.10(f)(4). (OMPP defines significant changes as any changes that may affect member accessibility to the Contractor's services and benefits.)

The Contractor must make written information available in English and Spanish and other prevalent non-English languages identified by OMPP, upon OMPP's or the member's request. In addition, the Contractor must identify additional languages that are prevalent among the Contractor's membership. For purposes of this requirement, prevalent language is defined as any language spoken by at least three percent (3%) of the general population in the Contractor's service area.

The Contractor must inform members that information is available upon request in alternative formats and how to obtain them. OMPP defines alternative formats as Braille, large font letters, audiotape, prevalent languages and verbal explanation of written materials. To the extent possible, written materials must not exceed a fifth grade reading level.

The Contractor must provide notification to OMPP, to the Enrollment Broker and to its members of any covered services that the Contractor or any of its sub-contractors or networks do not cover on the basis of moral or religious grounds and guidelines for how and where to obtain those services, in accordance with 42 CFR 438.102. This information must be relayed to the member before and during enrollment and within ninety (90) calendar days after adopting the policy with respect to any particular service.

The Contractor must comply with the requirements of 42 CFR 422.128 for maintaining written policies and procedures for advance directives. Each Contractor must maintain written policies and procedures concerning advance directives with respect to all adult individuals receiving medical care by or through the Contractor's health plan. Specifically, each Contractor must maintain written policies and procedures that meet requirements for advance directives in Subpart I of 42 CFR 489. Advance directives are defined in 42 CFR 489.100 as "a written instruction, such as a living will or durable power of attorney for health care, recognized under state law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated."

Written information on the Contractor's advance directive policies, including a description of applicable state law, must be provided to members in accordance with 42 CFR 438.10(g)(2) and 438.6(i). Written information must reflect changes in state law as soon as possible, but no later than ninety (90) calendar days after the effective date of the change. Each Contractor must provide written information to those individuals with respect to their rights under state law, and the Contractor's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience. See 42 CFR 422.128(b) for further information regarding this requirement.

The Contractor must inform individuals that complaints concerning noncompliance with the advance directive requirements may be filed with the State.

The Contractor must inform the members that, upon the member's request, the Contractor will provide information on the structure and operation of the Contractor and, in accordance with 42 CFR 438.6(h), will provide information on the Contractor's provider incentive plans.

Grievance, appeal and fair hearing procedures and timeframes must be provided to members in accordance with 42 CFR 438.10(g)(1). Please see Section 6.9 for further information about grievance, appeal and fair hearing procedures, as well as the kind of information that the Contractor must provide to members.

The Contractor will be responsible for developing and maintaining member education programs designed to provide the members with clear, concise and accurate information about the Contractor's program, the Contractor's network and the Hoosier Healthwise and HIP programs. The State encourages the Contractor to incorporate community advocates, support agencies, health departments, other governmental agencies and public health associations in its outreach and member education programs. The State encourages the Contractor to develop community partnerships with these types of organizations, in particular with school based health centers, community mental health centers, WIC clinics, county health departments and prenatal clinics to promote health and wellness within its membership.

The Contractor's educational activities and services should also address the special needs of specific Hoosier Healthwise and HIP subpopulations (e.g., pregnant women, newborns, early childhood, at-risk members, children with special needs) as well as its general membership. The Contractor must demonstrate how these educational interventions reduce barriers to health care and improve health outcomes for members.

The Contractor must have in place policies and procedures to ensure that materials are accurate in content, accurate in translation relevant to language or alternate formats and do not defraud, mislead or confuse the member. The Contractor must provide information requested by the State, or the State's designee, for use in member education and enrollment, upon request.

6.4.1 Member Handbook

The Contractor must develop one member handbook for its Hoosier Healthwise and HIP members. The Contractor's member handbook must be submitted annually for OMPP's review. The member handbook must include the Contractor's contact information and Internet website address and describe the terms and nature of services offered by the Contractor, including the following information required under 42 CFR 438.10(f)(6). The Managed Care Policies and Procedures Manual outlines the member handbook requirements.

The combined Hoosier Healthwise and HIP member handbook must include the following:

- Contractor's services and benefits
- The procedures for obtaining benefits, including authorization requirements
- Any restrictions on the member's freedom of choice among network providers, as well as the extent to which members may obtain benefits, including family planning services, from out-of-network providers

- The extent to which, and how, after-hours and emergency coverage are provided, as well as other information required under 42 CFR 438.10(f)(6)(viii)
- The post-stabilization care services rules set forth in 42 CFR 422.113(c)
- Applicable policy on referrals for specialty care and other benefits not provided by the member's PMP, if any
- HIP pregnancy policy
- HIP co-payments for emergency room services
- Information about the availability of pharmacy services and how to access pharmacy services
- Member rights and protections, as enumerated in 42 CFR 438.100. See Section 6.8 for further detail regarding member rights and protections.
- Responsibilities of members
- Special benefit provisions (for example, co-payments, deductibles, limits or rejections of claims) that may apply to services obtained outside the Contractor's network
- Procedures for obtaining out-of-network services
- Standards and expectations to receive preventive health services
- Policy on referrals to specialty care
- Procedures for notifying members affected by termination or change in any benefits, services or service delivery sites
- Procedures for appealing decisions adversely affecting members' coverage, benefits or relationship with the Contractor
- Procedures for changing PMPs
- Procedures for changing MCOs
- Procedures for making complaints, filing grievances and recommending changes in policies and services
- Information about advance directives
- How to request a POWER Account contribution or Hoosier Healthwise Package C (CHIP) premium recalculation in the event of a change in income, change in family size, etc.

6.4.2 Member Website

The Contractor must provide information to members through an Internet website in an OMPP-approved format (compliant with Section 508 of the US Rehabilitation Act) to ensure compliance with existing accessibility guidelines. The website must be live and meet the requirements of this section on the effective date of the Contract. OMPP must pre-approve the Contractor's website information and graphic presentations. The website must be accurate and current, culturally appropriate, written for understanding at a fifth grade reading level and available in English and Spanish. The Contractor must inform members that information is available upon request in alternative formats and how to obtain alternative formats. To minimize download and wait times, the website must avoid techniques or tools that require significant memory or disk resources or require special intervention on the user side to install plug-ins or additional software. The Contractor must date each web page, change the date with each revision and allow users print access to the information. Such website information must include, at minimum, the following:

- The Contractor's provider network identifying each provider's specialty, service location(s), hours of operation, phone numbers, public transportation access and other

demographic information as described in Section 7.11. The Contractor must update the on-line provider network information every two (2) weeks, at a minimum.

- The Contractor's contact information for member inquiries, member grievances and appeals
- The Contractor's member services phone number, TDD number, hours of operation and after-hours access numbers
- A member portal with access to electronic Explanation of Benefit (EOB) statements. For HIP members, the member portal should also include up-to-date POWER Account balance information, including the required annual and monthly contribution amounts and payments made.
- Preventive care and wellness information. For HIP, this information must include the preventive care services covered under the $500 preventive care benefit and the preventive care services that qualify a member for POWER Account roll over. For Hoosier Healthwise, this information should include information about well child visits and the Contractor's prenatal services.
- Information about the cost and quality of health care services, as further described in Section 6.4.5
- A description of the Contractor's disease management programs
- The member's rights and responsibilities, as enumerated in 42 CFR 438.100. Please see Section 6.8 for further details regarding member rights.
- The member handbook information
- Contractor telephone system scripts and "commercials-on-hold"
- Contractor-distributed literature regarding all health or wellness promotion programs that are offered by the Contractor
- Contractor's marketing brochures and posters
- Notification letters to members regarding Contractor decisions to terminate, suspend or reduce previously authorized covered services
- The Health Insurance Portability and Accountability Act (HIPAA) privacy statement
- Links to OMPP's website for general Medicaid, Hoosier Healthwise or HIP information
- A link to the State's preferred drug list and IHCP pharmacy locations
- Transportation access information (Hoosier Healthwise only)

- Information about how to access dental services by linking to the State's website (Hoosier Healthwise only)

- A list and brief description of each of the Contractor's member outreach and education materials

- The executive summary of Contractor's Annual Quality Management and Improvement Program Plan Summary Report

6.4.3 Preventive Care Information – Hoosier Healthwise and HIP

The Contractor is responsible for educating members regarding the importance of using preventive care services in accordance with preventive care standards. For Hoosier Healthwise, this would include information on EPSDT, well-child services and blood lead screenings. For HIP members, these plans must include reminders that encourage members to obtain the OMPP-recommended preventive services for their age, gender and pre-existing conditions, including an explanation of the member's ability to roll over the entire POWER Account balance if recommended preventive services are obtained.

6.4.4 POWER Account Education – HIP

This requirement applies to the Contractor's HIP line of business only.

The Contractor must establish a variety of methods, to be approved by OMPP, in which it will provide POWER Account education to members. In educating members about POWER Accounts, the Contractor should emphasize those features of POWER Accounts that help members stay healthy, be value- and cost-conscious and utilize services in a cost-efficient manner. The Contractor must explain the impact members' health seeking behavior will have on their ability to use a left over POWER Account balance to reduce the next benefit period's required POWER Account contribution, as well as their right to obtain a partial rebate of their POWER Account if they leave HIP.

POWER Account educational materials must include, at minimum, information about:

- The opportunity for employers to contribute to member POWER Accounts, including the fifty percent (50%) cap on employer contributions

- Non-payment policies, including termination from HIP if a contribution is not received within sixty (60) calendar days of its due date, inability to reapply for HIP for twelve (12) months and forfeiture of twenty five percent (25%) of remaining POWER Account balance

- How to request a POWER Account contribution recalculation in the event of a change in income, change in family size, etc.

- POWER Account roll over policies and obtaining recommended preventive care

6.4.5 Cost and Quality Information

Making cost and quality information available to members increases transparency and has the potential to reduce costs and improve quality. The Contractor must make cost and quality information available to members in order to facilitate more responsible use of health care services and inform health care decision-making. Example cost information includes average cost of common services, urgent versus emergent care costs, etc.

The Contractor must provide a member portal with access to electronic EOB statements for both is Hoosier Healthwise and HIP members. In addition, the Contractor must generate and mail EOB statements to, at minimum, HIP members on a monthly basis. For HIP members, the EOB statements must indicate when services are paid with POWER Account funds. The POWER Account Statement required in Section 4.3 and EOB information may be combined in a single statement for HIP members. The Contractor shall give HIP members an opportunity to receive e-mail alerts about EOB information on the member's secure web portal, in addition to or as an alternative to receiving the information by mail.

Provider quality information must also be made available to members. The Contractor must capture quality information about its network providers, and must make this information available to members. In making the information available to members, the Contractor must identify any limitations of the data. The Contractor must also refer members to quality information compiled by credible external entities (e.g., Hospital Compare, Leap Frog Group, etc.).

6.5 Member and Potential Member Communications Review and Approval

All member and potential member communications required in this section or otherwise developed by the Contractor must be pre-approved by OMPP. The Contractor must develop and include a Contractor-designated inventory control number on all member marketing, education, training, outreach and other member materials with a date issued or date revised clearly marked. The purpose of this inventory control number is to facilitate OMPP's review and approval of member materials and document its receipt and approval of original and revised documents.

The Contractor must submit all member and potential member communications, including letters, bulletins, forms, advertisements, notices, handbooks, brochures and any other marketing, educational or outreach materials to OMPP for review and approval at least thirty (30) calendar days prior to expected use and distribution. Substantive changes to member and potential member communications must also be submitted to OMPP for review and approval at least thirty (30) calendar days prior to use.

The Contractor shall not refer to or use the FSSA, OMPP or other state agency name or logo in its member and potential member communications without prior written approval. The Contractor must request in writing approval from OMPP for each desired reference or use at least thirty (30) calendar days prior to the reference or use. Any approval given for the FSSA, OMPP or other state agency name or logo is specific to the use requested, and shall not be interpreted as blanket approval. The Contractor shall include the State program logo(s) in their marketing or other member communication materials upon OMPP request.

OMPP will assess liquidated damages and impose other authorized remedies for the Contractor's non-compliance in the use or distribution of any non-approved member or potential member communications.

All OMPP-approved member and potential member communication materials must be available on the Contractor's provider website within three (3) business days of distribution.

6.6 Redetermination Assistance

Contractors may assist members in the eligibility redetermination process. Permitted assistance includes:

- Conducting outreach calls or sending letters to members reminding them to renew their eligibility and reviewing redetermination requirements with the member
- Answering questions about the redetermination process
- Helping the member obtain required documentation and collateral verification needed to process the application

In providing assistance during redetermination, Contractors shall not do any of the following:

- Discriminate against members, particularly high-cost members or members that have indicated a desire to change MCOs;
- Talk to members about changing MCOs (if a member has questions or requests to change MCOs, the Contractor must refer the member to the Enrollment Broker);
- Provide any indication as to whether the member will be eligible (this decision must be made by DFR);
- Engage in or support fraudulent activity in association with helping the member complete the redetermination process;
- Sign the member's redetermination form; or
- Complete or send redetermination materials to DFR on behalf of the member.

Contractors must provide redetermination assistance equally across the membership and be able to demonstrate to OMPP that their redetermination-related procedures are applied consistently for each member.

6.7 Member-Provider Communications

The Contractor shall comply with 42 CFR 438.102. The Contractor must not prohibit or restrict a health care professional from advising a member about his/her health status, medical care or treatment options, regardless of whether benefits for such care are provided under the Hoosier Healthwise or HIP programs, as long as the professional is acting within his/her lawful scope of practice. This provision does not require the Contractor to provide coverage for a counseling or referral service if the Contractor objects to the service on moral or religious grounds.

In accordance with 42 CFR 438.102(a), the Contractor must allow health professionals to advise the member on alternative treatments that may be self-administered and provide the member with any information needed to decide among relevant treatment options. Health professionals are free to advise members on the risks, benefits and consequences of treatment or non-treatment.

The Contractor must not prohibit health professionals from advising members of their right to participate in decisions regarding their health, including the right to refuse treatment and express preferences for future treatment methods. The Contractor may not take punitive action against a provider who requests an expedited resolution or supports a member's appeal.

6.8 Member Rights

The Contractor must guarantee the following rights protected under 42 CFR 438.100 to its members:

- The right to receive information in accordance with 42 CFR 438.10.
- The right to be treated with respect and with due consideration for his or her dignity and privacy.
- The right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.
- The right to participate in decisions regarding his or her health care, including the right to refuse treatment.
- The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other federal regulations on the use of restraints and seclusion.
- The right to request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in the HIPAA Privacy Rule set forth in 45 CFR parts 160 and 164, subparts A and E.
- The right to be furnished health care services in accordance with 42 CFR 438.206 through 438.210.

The Contractor must also comply with other applicable state and federal laws regarding member rights, as set forth in 42 CFR 438.100(d).

The Contractor must have written policies in place regarding the protected member rights listed above. The Contractor must have a plan in place to ensure that its staff and network providers take member rights into account when furnishing services to the Contractor's members. Members must be free to exercise protected member rights, and the Contractor must not discriminate against a member that chooses to exercise his or her rights.

6.9 Member Inquiries, Grievances and Appeals

The Contractor shall establish written policies and procedures governing the resolution of grievances and appeals. At a minimum, the grievance system must include a grievance process, an appeal process, expedited review procedures, external review procedures and access to the State's fair hearing system. The Contractor's grievances and appeals system, including the policies for recordkeeping and reporting of grievances and appeals, must comply with 42 CFR 438, Subpart

F, as well as IC 27-13-10 and IC 27-13-10.1 (if the Contractor is licensed as an HMO) or IC 27-8-28 and IC 27-8-29 (if the Contractor is licensed as an accident and sickness insurer), as described within the Managed Care Policies and Procedures Manual.

The term *appeal* is defined as a request for a review of an action. An *action,* as defined in 42 CFR 438.400(b), is the:

- Denial or limited authorization of a requested service, including the type or level of service;
- Reduction, suspension or termination of a previously authorized service;
- Denial, in whole or in part, of payment for a service;
- Failure to provide services in a timely manner, as defined by the State;
- Failure of a Contractor to act within the required timeframes; or
- For a resident of a rural area with only one Contractor, the denial of a member's request to exercise his or her right, under 42 CFR 438.52(b)(2)(ii), to obtain services outside the network (if applicable).

The term *grievance,* as defined in 42 CFR 43 8.400(b), is an expression of dissatisfaction about any matter other than an "action" as defined above. This may include dissatisfaction related to the quality of care of services rendered or available, rudeness of a provider or employee or the failure to respect the member's rights.

The Contractor must notify the requesting provider, and give the member written notice, of any decision considered an "action" taken by the Contractor, including any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested. The notice must meet the requirements of 42 CFR 438.404. See Section 8.3.2, Authorization of Services and Notices of Action for additional information.

The Contractor's appeals process must do the following:

- Allow members, or providers acting on the member's behalf, thirty (30) days from the date of action notice within which to file an appeal. A provider, acting on behalf of the member and with the member's written consent, may file an appeal.

- Ensure that oral requests seeking to appeal an action are treated as appeals. However, an oral request for an appeal must be followed by a written request, unless the member or the provider requests an expedited resolution.

- Maintain an expedited review process for appeals when the Contractor or the member's provider determines that pursuing the standard appeals process could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. The Contractor must dispose of expedited appeals within forty-eight (48) hours after the Contractor receives notice of the appeal, unless this timeframe is extended pursuant to 42 CFR 438.408 (c). In addition to the required written decision notice, the Contractor must make reasonable efforts to provide the member with oral notice of the disposition of the appeal.

- If the Contractor denies the request for an expedited resolution of a member's appeal, the Contractor must transfer the appeal to the standard twenty (20) business day timeframe

and give the member written notice of the denial within two (2) days of the expedited appeal request. The Contractor must also make a reasonable attempt to give the member prompt oral notice.

- The Contractor must acknowledge receipt of each standard appeal within three (3) business days.

- The Contractor must make a decision on standard, non-expedited, appeals within twenty (20) business days of receipt of the appeal. This timeframe may be extended up to ten (10) business days, pursuant to 42 CFR 438.408(c).

The Contractor's policies and procedures governing appeals must include provisions which address the following:

- The Contractor must not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a member, in accordance with 42 CFR 438.102. A provider, acting on behalf of the member and with the member's written consent, may file an appeal.

- The Contractor must not take punitive action against a provider who requests or supports an expedited appeal on behalf of a member.

- Throughout the appeals process, the Contractor must consider the member, representative or estate representative of a deceased member as parties to the appeal;

- Allow the member and member representative an opportunity to examine the member's case file, including medical records, and any other documents and records;

- Allow the member and member representative to present evidence, and allegations of fact or law, in person as well as in writing; and

- Upon determination of the appeal, ensure there is no delay in notification or mailing to the member and member representative the appeal decision. The Contractor's appeal decision notice must describe the actions taken, the reasons for the action, the member's right to request a State fair hearing, process for filing a fair hearing and other information set forth in 42 CFR 438.408(e).

In accordance with IC 27-13-10.1-1 and IC 27-8-29-1, the Contractor must maintain an external grievance procedure for the resolution of decisions related to an adverse utilization review determination, an adverse determination of medical necessity or a determination that a proposed service is experimental or investigational. An external review does not inhibit or replace the member's right to appeal a Contractor decision to a State fair hearing.

- Within forty-five (45) days of receipt of the appeal decision, a member, or a member's representative may file a written request for a review of the Contractor's decision by an independent review organization (IRO).

- Within seventy-two (72) hours, for an expedited appeal, or fifteen (15) business days for a standard appeal, the independent review organization will render a decision to uphold

or reverse the Contractor's decision.

- The determination made by the independent review organization is binding on the Contractor.

FSSA maintains a fair hearing process which allows members the opportunity to appeal the Contractor's decisions to the State. Appeal procedures for applicants and recipients of Medicaid are found at 405 IAC 1.1. The State fair hearing procedures include the following requirements:

- Within thirty (30) days of exhausting the Contractor's internal procedures, the member may request an FSSA fair hearing.

- The parties to the FSSA fair hearing shall include the Contractor, as well as the member and his or her representative or the representative of a deceased member's estate.

- The Contractor must include the FSSA fair hearing process as part of the written internal process for resolution of appeals and must describe the fair hearing process in the member handbook.

In certain member appeals, the Contractor will be required to continue the member's benefits pending the appeal, in accordance with 42 CFR 438.420.

The Contractor must authorize or provide disputed services promptly, and as expeditiously as the member's health condition requires if the services were not furnished while the appeal is pending and the Contractor or the FSSA fair hearing officer reverses a decision to deny, limit or delay services.

The Contractor must pay for disputed services, in accordance with state policy and regulations, if the Contractor or the FSSA fair hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending.

The Contractor's internal grievance and appeals procedures must include the following components:

- The Contractor must acknowledge receipt of each grievance and appeal.

- The Contractor must notify members of the disposition of grievances and appeals pursuant to IC 27-13-10-7 (if the Contractor is licensed as an HMO) or IC 27-8-28-16 (if the Contractor is licensed as an accident and sickness insurer).

- The Contractor must provide assistance in completing forms and other procedural steps not limited to providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability.

- The Contractor must ensure that decision makers on grievances and appeals were not involved in previous levels of review or decision-making and are health care professionals with clinical expertise in treating the member's condition or disease if the decision will be in regard to any of the following:

- An appeal of a denial based on lack of medical necessity
- A grievance regarding denial of expedited resolution of an appeal
- Any grievance or appeal involving clinical issues

The Contractor's policies and procedures governing grievances must include provisions that allow for the following filing, notice and resolution timeframes:

- Members must be allowed to file grievances orally or in writing within sixty (60) calendar days of the occurrence of the matter that is the subject of the grievance. Members may file a grievance regarding any matter other than those described in the definition of an action.
- The Contractor must acknowledge receipt of each grievance within three (3) business days. The Contractor must make a decision on non-expedited grievances within twenty (20) business days of receipt of the grievance. This timeframe may be extended up to ten (10) business days if resolution of the matter requires additional time. A letter notifying the member of this extension is required.

6.9.1 Member Notice of Grievance, Appeal and Fair Hearing Procedures

The Contractor must provide specific information regarding member grievance, appeal and state fair hearing procedures and timeframes to members, as well as providers and subcontractors at the time they enter a contract with the Contractor. The information provided must be approved by OMPP and, as required under 42 CFR 438.10(g)(1), include the following:

- The right to file grievances and appeals
- The requirements and timeframes for filing a grievance or appeal
- The availability of assistance in the filing process
- The toll-free numbers that the member can use to file a grievance or appeal by phone
- The fact that, if requested by the member and under certain circumstances: 1) benefits will continue if the member files an appeal or requests a FSSA fair hearing within the specified timeframes; and 2) the member may be required to pay the cost of services furnished during the appeal if the final decision is adverse to the member.
- For a FSSA fair hearing:
  - The right to a hearing;
  - The method for obtaining a hearing; and
  - The rules that govern representation at the hearing

6.10 Oral Interpretation Services

The Contractor must provide free oral interpretation services to its members seeking health care-related services in a provider's service location in accordance with 42 CFR 438.10 (c)(4). The Contractor must notify its members of the availability of these services and how to obtain them.

Oral interpretation services must include sign language interpretation services for the deaf.

6.11 Cultural Competency

The Contractor shall provide services in a culturally competent manner. The Contractor shall incorporate the Office of Minority Health's National Standards on Culturally and Linguistically Appropriate Services (CLAS) into the provision of health care services for its members. The CLAS standards are available at http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=15.

7.0 Provider Network Requirements

The Contractor must ensure that its provider network is supported by written provider agreements, is available and geographically accessible and provides adequate numbers of facilities, physicians, ancillary providers, service locations and personnel for the provision of high-quality covered services for its members, in accordance with 42 CFR 438.206. The Contractor must also ensure that all of its contracted providers are IHCP providers and can respond to the cultural, racial and linguistic needs of its member populations. The network must be able to handle the unique needs of its members, particularly those with special health care needs. The Contractor will be required to participate in any state efforts to promote the delivery of covered services in a culturally competent manner.

In some cases, members may receive out-of-network services. In order to receive reimbursement from the Contractor, out-of-network providers must be IHCP providers. The Contractor shall encourage out-of-network providers, particularly emergency services providers, to enroll in the IHCP. An out-of-network provider must be enrolled in the IHCP in order to receive payment from the Contractor.

Further information about IHCP Provider Enrollment is located at:
http://www.indianamedicaid.com/ihcp/ProviderServices/enrollment_provider.asp

7.1 Network Development

OMPP requires the Contractor to develop and maintain a comprehensive network to provide services to its Hoosier Healthwise and HIP members. The network must include providers serving special needs populations. For its Hoosier Healthwise population, the network must include providers serving children with special health care needs.

The Contractor must develop a comprehensive network prior to the effective date of the Contract. The Contractor shall be required to have an open network and accept any IHCP provider acting within his or her scope of practice until the Contractor demonstrates that it meets the access requirements. OMPP reserves the right to delay initial member enrollment in the Contractor's plan if the Contractor fails to demonstrate a complete and comprehensive network.

With approval from OMPP, Contractors that can demonstrate that they have met all access, availability and network composition requirements may require members to use in-network providers, with the exception of certain self-referral providers. The Contractor must provide

ninety (90) calendar day advance notice to OMPP of changes to the network that may affect access, availability and network composition. OMPP will regularly and routinely monitor network access, availability and adequacy. OMPP will impose remedies, as set forth in Attachment B to the Contract, or require the Contractor to maintain an open network, if the Contractor fails to meet the network composition requirements.

In accordance with 42 CFR 438.206(b)(1), the Contractor must consider the following elements when developing and maintaining its provider network:

- The anticipated enrollment;
- The expected utilization of services, taking into consideration the characteristics and health care needs of the Contractor's Hoosier Healthwise and HIP members;
- The numbers and types (in terms of training, experience and specialization) of providers required to furnish the contracted services;
- The numbers of network providers who are not accepting new members; and
- The geographic location of providers and members, considering distance, travel time, the means of transportation ordinarily used by members and whether the location provides physical access for members with disabilities.

OMPP will assess liquidated damages and impose other authorized remedies for Contractor's non-compliance with the network development and network composition requirements.

The Contractor must contract its specialist and ancillary provider network prior to receiving enrollment. OMPP reserves the right to implement corrective actions and will assess liquidated damages as described in Attachment B to the Contract if the Contractor fails to meet and maintain the specialist and ancillary provider network access standards. OMPP's corrective actions may include, but are not limited to, withholding or suspending new member enrollment from the Contractor until the Contractor's specialist and ancillary provider network is in place. OMPP will monitor the Contractor's specialist and ancillary provider network to confirm the Contractor is maintaining the required level of access to specialty care. OMPP reserves the right to increase the number or types of required specialty providers at any time.

7.2 Network Composition Requirements

In compliance with 42 CFR 438.207, the Contractor must:

- Serve the expected enrollment
- Offer an appropriate range of services and access to preventive and primary care services for the population expected to be enrolled
- Maintain a sufficient number, mix and geographic distribution of providers as specified below

At the beginning of its Contract with the State, the Contractor shall submit regular network access reports as directed by OMPP. Once the Contractor demonstrates compliance with OMPP's access standards, the Contractor shall submit network access reports on an annual basis and at any time there is a significant change to the provider network (i.e., the Contractor no longer meets the network access standards). OMPP reserves the right to expand or revise the network requirements, as it deems appropriate. The Contractor must not discriminate with respect to participation, reimbursement or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable state law, solely on the basis of such license or certification as stated in 42 CFR 438.12. However, the Contractor is not prohibited from including providers only to the extent necessary to meet the needs of the Contractor's members or from establishing any measure designed to maintain quality and control costs consistent with the Contractor's responsibilities.

As required under 42 CFR 438.206, the Contractor must ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial members, if the Contractor also serves commercial members. The Contractor must also make covered services available twenty four (24)-hours-a-day, seven (7)-days-a-week, when medically necessary. In meeting these requirements, the Contractor must:

- Establish mechanisms to ensure compliance by providers
- Monitor providers regularly to determine compliance
- Take corrective action if there is a failure to comply

The Contractor must provide OMPP written notice at least ninety (90) calendar days in advance of the Contractor's inability to maintain a sufficient network in any county.

7.2.1 Acute Care Hospital Facilities

The Contractor must provide a sufficient number and geographic distribution of acute care hospital facilities to serve the expected enrollment. Inpatient services are covered when such services are prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member's condition.

7.2.2 Primary Medical Provider (PMP) Requirements

PMPs may contract as a PMP with one or multiple MCOs. A PMP may also participate as a specialist in another MCO. The PMP may maintain a patient base of non-Hoosier Healthwise and HIP members (e.g., commercial, traditional Medicaid or Care Select members). The Contractor may not prevent the PMP from contracting with other MCOs.

The Contractor must assure that each member has a PMP who is responsible for providing an ongoing source of primary care appropriate to the member's needs. PMPs must coordinate each member's physical and behavioral health care and make any referrals necessary. In Hoosier Healthwise, but not HIP, a referral from the member's PMP is required when the member receives physician services from any provider other than his or her PMP, unless the service is a self-referral service as set forth in Section 5.2.

OMPP requires the Contractor to provide access to PMPs within at least thirty (30) miles of the member's residence. Providers that may serve as PMPs include internal medicine physicians, general practitioners, family medicine physicians, pediatricians, obstetricians (Hoosier Healthwise only), gynecologists and endocrinologists (if primarily engaged in internal medicine).

The Contractor's PMP contract must state the PMP panel size limits, and the Contractor must assess the PMP's non-Hoosier Healthwise and HIP practice when assessing the PMP's capacity to serve the Contractor's members. The fiscal agent will maintain a separate panel for PMPs contracted with more than one MCO. OMPP will monitor the Contractor's PMP network to evaluate its member-to-PMP ratio.

The Contractor must have a mechanism in place to ensure that contracted PMPs provide or arrange for coverage of services twenty four (24)-hours-a day, seven (7)-days-a-week and that PMPs have a mechanism in place to offer members direct contact with their PMP, or the PMP's qualified clinical staff person, through a toll-free telephone number twenty four (24)-hours-a-day, seven (7)-days-a-week. Each PMP must be available to see members at least three (3) days per week for a minimum of twenty (20) hours per week at any combination of no more than two (2) locations. The Contractor must also assess the PMP's non-Hoosier Healthwise and HIP practice to ensure that the PMP's Hoosier Healthwise and HIP population is receiving accessible services on an equal basis with the PMP's non-Hoosier Healthwise and HIP population.

The Contractor must ensure that the PMP provide "live voice" coverage after normal business hours. After-hour coverage for the PMP may include an answering service or a shared-call system with other medical providers. The Contractor must ensure that members have telephone access to their PMP (or appropriate designate such as a covering physician) in English and Spanish twenty four (24)-hours-a-day, seven (7)-days-a-week.

The Contractor must ensure that PMPs are maintaining the PMP medical care standards and practice guidelines detailed in the IHCP Provider Manual. The Contractor must monitor medical care standards to evaluate access to care and quality of services provided to members and to evaluate providers regarding their practice patterns.

7.2.3 Specialist and Ancillary Provider Network Requirements

In addition to maintaining a network of PMPs, the Contractor must provide and maintain a comprehensive network of IHCP provider specialists and ancillary providers.

As with PMPs, specialist and ancillary providers are <u>not</u> limited to serve in only one Contractor network. In addition, physicians contracted as a PMP with one Contractor may contract as a specialist with other Contractors.

The Contractor must ensure that specialists are maintaining the medical care standards and practice guidelines detailed in the IHCP Provider Manual. OMPP requires the Contractor to monitor medical care standards to evaluate access to care and quality of services provided to members and to evaluate providers regarding their practice patterns.

OMPP requires the Contractor to develop and maintain a comprehensive network of specialty providers listed below. For providers identified with an asterisk (*), the Contractor must

provide, at a minimum, two specialty providers within sixty (60) miles of the member's residence. For providers identified with two asterisks (**), the Contractor must provide, at a minimum, one specialty provider within ninety (90) miles of the member's residence.

Specialties	Ancillary Providers
➢ Anesthesiologists* ➢ Cardiologists* ➢ Cardiothoracic surgeons** ➢ Dentists/Oral Surgeons (HIP only)** ➢ Dermatologists** ➢ Endocrinologists* ➢ Gastroenterologists* ➢ General surgeons* ➢ Hematologists ➢ Infectious disease specialists** ➢ Interventional radiologists** ➢ Nephrologists* ➢ Neurologists* ➢ Neurosurgeons** ➢ Non-hospital based anesthesiologist (e.g., pain medicine)** ➢ OB/GYNs* ➢ Occupational therapists* ➢ Oncologists* ➢ Ophthalmologists* ➢ Optometrists* ➢ Orthopedic surgeons* ➢ Orthopedists ➢ Otolaryngologists ➢ Pathologists** ➢ Physical therapists* ➢ Psychiatrists* ➢ Pulmonologists* ➢ Radiation oncologists** ➢ Rheumatologists** ➢ Speech therapists* ➢ Urologists*	➢ Diagnostic testing* ➢ Durable Medical Equipment providers ➢ Home Health ➢ Prosthetic suppliers**

OMPP requires that the Contractor maintain different network access standards for the listed ancillary providers as follows:

- Two durable medical equipment providers must be available to provide services to the Contractor's members in each county or contiguous county

- Two home health providers must be available to provide services to the Contractor's members in each county or contiguous county

In addition, the Contractor must demonstrate the availability of providers with training, expertise and experience in providing smoking cessation services, especially to pregnant women. Evidence that providers are trained to provide smoking cessation services must be available during OMPP's monthly onsite visits.

The Contractor must contract with the Indiana Hemophilia and Thrombosis Center or a similar OMPP-approved, federally recognized treatment center. This requirement is based on the findings of the Centers for Disease Control and Prevention (CDC) which illustrate that persons affected by a bleeding disorder receiving treatment from a federally recognized treatment center require fewer hospitalizations, experience less bleeding episodes and experience a forty percent (40%) reduction in morbidity and mortality.

The Contractor must arrange for laboratory services only through those IHCP enrolled laboratories with Clinical Laboratory Improvement Amendments (CLIA) certificates.

7.2.4 Non-psychiatrist Behavioral Health Providers

Contractors must include psychiatrists in their networks as required above. The Division of Mental Health and Addiction (DMHA) conducts regular annual Consumer Service Reviews to evaluate the quality of care provided in CMHCs. In addition to the regular oversight that the Contractor provides for contracted CMHCs, the Contractors must utilize the results of DMHA's review to inform contracting decisions, to monitor contracted CMHCs and to develop improvement plans with contracted CMHCs.

The Contractor must meet the following network composition requirements for non-psychiatrist behavioral health providers:

In urban areas, the Contractor must provide at least one behavioral health provider within thirty (30) minutes or thirty (30) miles; in rural areas, one within forty-five (45) minutes or forty-five (45) miles. The availability of professionals will vary, but access problems may be especially acute in rural areas. The Contractor must provide assertive outreach to members in rural areas where behavioral health services may be less available than in more urban areas. The Contractor also must monitor utilization in rural and urban areas to assure equality of service access and availability. The following list represents behavioral health providers that should be available in the Contractor's network:

- Outpatient mental health clinics
- Community mental health centers
- Psychologists
- Certified psychologists
- Health services providers in psychology (HSPPs)
- Certified social workers
- Certified clinical social workers
- Psychiatric nurses
- Independent practice school psychologists
- Advanced practice nurses under IC 25-23-1-1(b)(3), credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center
- Persons holding a master's degree in social work, marital and family therapy or mental health counseling (under the Clinic Option)

7.2.5 Physician Extenders

Physician extenders are health care professionals who are licensed to practice medicine under the supervision of a physician. Physician extenders can perform some of the services that physicians provide, such as physical exams, preventive health care and education. Some can also assist in surgery and write prescriptions.

Appropriate use of physician extenders can have a positive influence on cost, quality and access. Physician extenders can perform routine or straightforward services at a lower cost than a physician, allowing physicians to focus on more complicated patient problems. Physician extenders also allow patients to be seen promptly for preventive visits or less complicated health problems, which improves access to care and may allow more Medicaid patients to be seen.

According to Indiana law, the following physician extenders are licensed to provide care in Indiana:

- Advanced practice nurses, including nurse practitioners, nurse midwives and clinical nurse specialists
- Physician assistants
- Certified registered nurse anesthetists

Contractors must implement initiatives to encourage providers to use physician extenders. Examples of these types of initiatives include:

- Educate providers about the benefits of physician extenders
- Educate providers about reimbursement policies for physician extenders
- Offer financial or non-financial incentives to providers who increase their use of physician extenders. Any financial incentives must be positive, not punitive.
- Collaborate with physician-extender training programs in Indiana. Collaboration could include providing internships or practicum for physician extenders, expanding the number of training slots for physician extenders, etc.

State Medicaid programs are required to make nurse practitioner services available to Medicaid recipients in accordance with 42 CFR 441.22. Members are allowed to use the services of nurse practitioners out-of-network if no nurse practitioner is available in the Contractor's network. If nurse practitioner services are available through the Contractor, the Contractor must inform the member that nurse practitioner services are available.

7.2.6 Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

Since Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) are essential safety net providers, OMPP strongly encourages the Contractor to contract with FQHCs and RHCs that are willing to contract with the Contractor and meet all of the Contractor's requirements regarding the ability of these providers to provide quality services. The Contractor must reimburse FQHCs and RHCs for services at no less than the level and amount of payment that the Contractor would make to a non-FQHC or non-RHC provider for the same services. In HIP, Contractors must make covered services provided by FQHCs and

RHCs available to members out-of-network if an FQHC or RHC is not available in the member's service area within the Contractor's network.

In accordance with the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), OMPP will make supplemental payments to FQHCs and RHCs that subcontract (directly or indirectly) with the Contractor. These supplemental payments represent the difference, if any, between the payment to which the FQHC or RHC would be entitled for covered services under the Medicaid provisions of BIPA and the payments made by the Contractor.

OMPP requires the Contractor to identify any performance incentives it offers to the FQHC or RHC. OMPP must review and approve any performance incentives. The Contractor must report all such FQHC and RHC incentives which accrue during the Contract period related to the cost of providing FQHC-covered or RHC-covered services to its members along with any fee-for-service and/or capitation payments in the determination of the amount of direct reimbursement paid by the Contractor to the FQHC or RHC. If the incentives vary between the Contractor's Hoosier Healthwise and HIP lines of business, the Contractor must so specify in its reporting to OMPP.

The Contractor shall perform quarterly claim reconciliation with each contracted FQHC or RHC to identify and resolve any billing issues that may impact the clinic's annual reconciliation conducted by OMPP.

Annually, OMPP requires the Contractor to provide the Contractor's utilization and reimbursement data for each FQHC and RHC in each month of the reporting period. A separate report shall be provided for the Contractor's Hoosier Healthwise and HIP lines of business. The report must be completed in the form and manner set forth in the Contractor Reporting Manual, which shall be provided following the Contract award date. For Hoosier Healthwise, the data shall be submitted on an incurred claims basis, including separate reporting of Package A/B FFS claims, Package A/B capitation claims, Package C FFS claims and Package C capitation claims. For HIP, the data shall be submitted on a paid claims basis. The State reserves the right to require Hoosier Healthwise data to be submitted on a paid claims basis.

For both programs, the submitted FQHC and RHC data must be accurate and complete. The Contractor must pull the data by NPI or LPI, rather than other means, such as a Federal Tax ID number. The Contractor shall establish a process for validating the completeness and accuracy of the data, and a description of this process must be available to OMPP upon request. The claims files should not omit claims for practitioners rendering services at the clinic nor should the files contain claims for practitioners who did not practice at the clinic.

In addition, OMPP requires the FQHC or RHC and the Contractor to maintain and submit records documenting the number and types of valid encounters provided to members each month. Capitated FQHCs and RHCs must also submit encounter data (e.g., in the form of shadow claims to the Contractor) each month. The number of encounters will be subject to audit by OMPP or its representatives.

The Contractor shall work with each FQHC and RHC in assisting OMPP and/or its designee in the resolution of disputes concerning year-end reconciliations between the federally required interim payments (made by OMPP to each FQHC and RHC on the basis of

provider reported encounter activity) and the final accounting that is based on the actual encounter data provided by the Contractor.

7.2.7 School-based Health Care Services – Hoosier Healthwise

Contractors must plan for, develop and/or enhance relationships with school-based health centers (SBHCs) with the goal of providing accessible quality preventive and primary health care services to school-aged Hoosier Healthwise members.

A school-based health center (SBHC) is a health center located in a school or on school grounds that provides on-site comprehensive preventive and primary health services including behavioral health, oral health, ancillary and enabling services. These services may include a wide variety of preventive services including general health screening or assessments, EPSDT screenings, laboratory and diagnostic screenings, immunizations, first aid, family planning counseling and services, prenatal and postpartum care, dental services, behavioral health services, drug and alcohol abuse counseling, patient education and other services based on the student's need and on the philosophy of the school administration.

SBHCs are becoming increasingly important in delivering preventive and primary health care services to school age children and adolescents. SBHCs are in a unique position to link children and adolescents to the health care system due to students' proximity and open access to health center services. The school setting additionally offers providers considerable opportunity and flexibility in engaging and reaching students. SBHCs' success at providing access to critical physical and behavioral health services, reducing school absenteeism and promoting appropriate utilization of health services has been well-documented.

Onsite health care providers at SBHCs generally include a nurse practitioner or physician assistant who operates under the standing orders of a physician, a consultant physician and a clinically trained behavioral health practitioner.

SBHCs have varying capacities and resources to deliver health care. For purposes of this procurement, SBHCs are not permitted to serve as PMPs. However, Contractors are encouraged to be creative in their approaches to collaborating with SBHCs and to begin to develop affiliations with SBHCs with the potential of expanding those affiliations and the scope of services available in SBHCs in the future. The following are some examples of the types and levels of services acceptable in SBHCs:

- The SBHC coordinates care with the child's PMP, who assumes responsibility for care whenever the SBHC closes. The SBHC can deliver preventive and primary medical care, but may rely on its partner for year-round accessibility and twenty four (24)-hour day coverage.

- The SBHC provides a limited range of services. For example, the SBHC may be able to provide services such as preventive medical care, health education, reproductive health care, behavioral health services, dental services and immunizations and may also have limited hours of operation. The SBHC refers the child back to their PMP for the majority of their primary care.

Contractors' relationships with SBHCs will vary depending on the resources available in their areas. The following list includes examples of possible Contractor relationships with Indiana SBHCs, not requirements for the Hoosier Healthwise program:

- FQHCs, health systems or other organizations contracted with a Contractor may sponsor an SBHC. The Contractor reimburses the sponsoring organization, which reimburses the SBHC for care provided to members enrolled in the Contractor.

- A Contractor can include SBHCs in its provider network. The Contractor reimburses the SBHC for care provided to members enrolled in the Contractor.

- Contractors may allow members to self-refer to an SBHC, for example, for a prescribed set of acute care visits and Contractors can reimburse SBHCs on a fee-for-service basis. The primary care functions and reimbursement stay with the child's PMP but, the SBHC serves as an acute care provider.

- The SBHC can function as a satellite office site for existing contracted providers.

- Contractors can reimburse a SBHC for care provided to enrolled members as an out-of-network provider.

To avoid duplicative services, promote continuity of care and develop strong relationships between SBHCs and PMPs, the SBHC should coordinate care and refer the child to their PMP for follow-up.

7.3 Provider Enrollment and Disenrollment

The Contractor must follow established procedures to enroll and disenroll providers, including PMPs. In enrolling and disenrolling providers, the Contractor must distinguish whether the provider participates in Hoosier Healthwise, HIP or both programs. The Managed Care Policies and Procedures Manual provides detailed information on PMP and provider enrollment and disenrollment procedures.

To process provider enrollments and disenrollments with the Contractor, the Contractor must submit the required information to the State fiscal agent through WebInterchange. For PMP agreements which are due to be effective with the Contract on January 1, 2011, the State fiscal agent will guarantee that all complete and accurate provider enrollment requests it receives by December 1, 2010, will be processed to be effective on January 1, 2011.

The Contractor must report PMP disenrollments to the State fiscal agent's Provider Enrollment unit by mail, fax or e-mail. The Contractor must first notify the State fiscal agent of the intent to disenroll a PMP within five (5) business days of the receipt/issuance of the PMP's disenrollment. The fiscal agent must receive enrollment/disenrollment requests at least five (5) business days prior to the 24th day of the month before the date the Contractor desires the enrollment or disenrollment to become effective. OMPP reserves the right to take corrective actions if the Contractor does not notify the State fiscal agent in a timely manner.

OMPP reserves the right to immediately disenroll any provider if the provider becomes ineligible to participate in IHCP.

If a PMP disenrolls from the Hoosier Healthwise or HIP program, but remains an IHCP provider, the Contractor must assure that the PMP provides continuation of care for his/her Hoosier Healthwise and/or HIP members for a minimum of thirty (30) calendar days or until the member's link to another PMP becomes effective.

When a PMP disenrolls from Hoosier Healthwise or HIP, the Contractor is responsible for assisting members assigned to that PMP in selecting a new PMP within the Contractor's network. If the member does not select another PMP, the Contractor shall assign the member to another PMP in the Contractor's network before the original PMP's disenrollment is effective.

The Contractor must make a good faith effort to provide written notice of a provider's disenrollment to any member that has received primary care services from that provider or otherwise sees the provider on a regular basis. Such notice must be provided within fifteen (15) calendar days of the Contractor's receipt or issuance of the provider termination notice.

7.4 Provider Agreements

The Contractor must have a process in place to review and authorize all network provider contracts. The Contractor must submit a model or sample contract of each type of provider agreement to OMPP for review and approval at least sixty (60) calendar days prior to the Contractor's intended use. Sample contracts should also be submitted in each Bidder's response to the RFS. If the Bidder is awarded the Contract, the Bidder must notify OMPP of any changes to the sample contracts within three (3) weeks of the Contract award date.

To allow sufficient processing time for the enrollment of the PMP and ensure an effective date of January 1, 2011, the Contractor must submit the completed PMP enrollment request to the State fiscal agent through WebInterchange prior to December 1, 2010. All provider agreements signed under a previous Contract with the State expire December 31, 2010 with the expiration of the State Contract. Provider agreements to be effective on or after January 1, 2011 may not be signed prior to the release date of the RFS.

The Contractor must include in all of its provider agreements provisions to ensure continuation of benefits. The Contractor must identify and incorporate the applicable terms of its Contract with the State and any incorporated documents, including the RFS. Under the terms of the provider services agreement, the provider must agree that the applicable terms and conditions set out in the RFS, the Contract, any incorporated documents and all applicable state and federal laws, as amended, govern the duties and responsibilities of the provider with regard to the provision of services to members. The requirement that subcontracts indemnify and hold harmless the State of Indiana do not extend to the contractual obligations and agreements between the Contractor and health care providers or other ancillary medical providers that have contracted with the Contractor.

In addition to the applicable requirements for subcontracts in Section 2.8, the provider agreements must meet the following requirements:

- Describe a written provider claim dispute resolution process.

- Require each provider to maintain a current IHCP provider agreement and to be duly licensed in accordance with the appropriate state licensing board and remain in good standing with said board.

- Require each provider to submit all claims that do not involve a third party payer for services rendered to the Contractor's members within ninety (90) calendar days or less from the date of service. The Contractor shall waive the timely filing requirement in the case of claims for members with retroactive coverage, such as presumptively eligible pregnant women and newborns.

- Include a termination clause stipulating that the Contractor must terminate its contractual relationship with the provider as soon as the Contractor has knowledge that the provider's license or IHCP provider agreement has terminated.

- Terminate the provider's agreement to serve the Contractor's Hoosier Healthwise and HIP members at the end of the Contract with the State.

- Monitor providers and apply corrective actions for those who are out of compliance with OMPP's or the Contractor's standards.

- Obligate the terminating provider to submit all encounter claims for services rendered to the Contractor's members while serving as the Contractor's network provider and provide or reference the Contractor's technical specifications for the submission of such encounter data.

- Not obligate the provider to participate under exclusivity agreements that prohibit the provider from contracting with other state contractors.

- Provide the PMP with the option to terminate the agreement without cause with advance notice to the Contractor. Said advance notice shall not have to be more that ninety (90) calendar days.

- Provide a copy of a member's medical record at no charge upon reasonable request by the member, and facilitate the transfer of the member's medical record to another provider at the member's request.

- Require each provider to agree that it shall not seek payment from the State for any service rendered to a Hoosier Healthwise or HIP member under the agreement.

The Contractor must have written policies and procedures for registering and responding to claims disputes for out-of-network providers, in accordance with the claims dispute resolution process for non-contracted providers outlined in 405 IAC 1-1.6-1.

7.5 Provider Credentialing

The Contractor must have written credentialing and re-credentialing policies and procedures for ensuring quality of care is maintained or improved and assuring that all contracted providers hold current state licensure and enrollment in the IHCP. The Contractor's credentialing and re-credentialing process for all contracted providers must meet the National Committee for Quality

Assurance (NCQA) guidelines. The same provider credentialing standards must apply across both the Hoosier Healthwise and HIP programs.

The Contractor shall use OMPP's standard provider credentialing form during the credentialing process. The Contractor must ensure that providers agree to meet all of OMPP's and the Contractor's standards for credentialing PMPs and specialists, and maintain IHCP manual standards, including:

- Compliance with state record keeping requirements
- OMPP's access and availability standards
- Other quality improvement program standards

As provided in 42 CFR 438.214(c), the Contractor's provider credentialing and selection policies must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. The Contractor must not employ or contract with providers that have been excluded from participating in federal health care programs under Section 1128 or Section 1128A of the Social Security Act.

7.6 Medical Records

The Contractor must assure that its records and those of its participating providers document all medical services that the member receives in accordance with state and federal law. The provider's medical record must include, at a minimum:

- Prescriptions for medications
- Inpatient discharge summaries
- Patient histories (including immunizations) and physicals
- A list of substances used and/or abused, including alcohol, smoking and legal and illegal drugs
- A record of outpatient, inpatient and emergency care, specialist referrals, ancillary care, laboratory and x-ray tests and findings

The Contractor's providers must maintain members' medical records in a detailed and comprehensive manner that conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates an accurate system for follow-up treatment. Medical records must be legible, signed and dated and maintained for at least seven (7) years as required by state and federal regulations.

The Contractor's providers must provide a copy of a member's medical record upon reasonable request by the member at no charge, and the provider must facilitate the transfer of the member's medical record to another provider at the member's request.

Confidentiality of, and access to, medical records must be provided in accordance with the standards mandated in the Health Insurance Portability and Accountability Act (HIPAA) and all other state and federal requirements.

The Contractor's providers must permit the Contractor and representatives of OMPP to review members' medical records for the purposes of monitoring the provider's compliance with the medical record standards, capturing information for clinical studies, monitoring quality or any other reason, in accordance with 405 IAC 1-5-2. OMPP encourages Contractors to use technology, including the participation in health information exchanges, where appropriate to transmit and store medical record data. See Section 9.8 for more information regarding electronic health records and data sharing requirements.

7.7 Provider Education and Outreach

The Contractor must educate its contracted providers, including behavioral health providers, regarding provider requirements and responsibilities, the Contractor's prior authorization policies and procedures, clinical protocols, member's rights and responsibilities, claims dispute resolution process, pay-for-performance programs and any other information relevant to improving the services provided to the Contractor's Hoosier Healthwise and HIP members.

The Contractor must develop and include a Contractor-designated inventory control number on all provider communications, including letters, forms, bulletins and promotional, educational, training, informational or other outreach materials, with a date issued or date revised clearly marked. The purpose of this inventory control number is to facilitate OMPP's review and approval of all provider communications and documentation of its receipt and approval of original and revised documents.

The Contractor must submit all provider communication materials designed for distribution to, or use by, contracted providers to OMPP for review and approval at least thirty (30) calendar days prior to use and distribution. The Contractor must also submit any material changes to previously approved provider communication materials to OMPP for review and approval at least thirty (30) calendar days prior to use and distribution. The Contractor must receive approval from OMPP prior to distribution or use of materials. OMPP's decision regarding any communication materials is final. The Contractor shall include the State program logo(s) in their provider communication materials upon OMPP request.

The Contractor shall not refer to or use the FSSA, OMPP or other state agency name or logo in its provider communications without prior written approval. The Contractor must request in writing approval from OMPP for each desired reference or use at least thirty (30) calendar days prior to the reference or use. Any approval given for the FSSA, OMPP or other state agency name or logo is specific to the use requested, and shall not be interpreted as blanket approval.

All OMPP-approved provider communication materials must be available on the Contractor's provider website within three (3) business days of distribution. The provider communication materials must be organized online in a user-friendly, searchable format by communication type and subject.

In addition to developing its own provider education and outreach materials, the Contractor shall be required to coordinate with OMPP-sponsored IHCP provider outreach activities upon request.

7.7.1 Additional Education for HIP Providers

For its HIP providers, the Contractor must provide education and outreach about the POWER Account, including preventive care and roll over, co-payments for emergency room services and the POWER Account debit card and payment procedures. The Contractor must also educate its HIP providers that pregnancy-related services are not covered under HIP and must emphasize the importance of transferring pregnant women out of HIP and into Hoosier Healthwise Package B for coverage during their pregnancy. The Contractor must prepare written materials on how a provider can get reimbursed for pregnancy-related services if a HIP member becomes pregnant.

7.8 Contractor Communications with Providers

The Contractor must have in place policies and procedures to maintain frequent communications and provide information to its provider network. As required by 42 CFR 438.207(c), the Contractor must notify OMPP of significant changes that may affect provider procedures at least thirty (30) calendar days prior to notifying its provider network of the changes. The Contractor must give providers forty-five (45) calendar days advance notice of significant changes that may affect the providers' procedures (e.g., changes in subcontractors). The Contractor must post a notice of the changes on its website to inform both network and out-of-network providers and make payment policies available to non-contracted providers upon request.

Because most pharmacy services are covered by Indiana Medicaid FFS under the pharmacy benefit consolidation, Contractors must educate providers about which pharmacy services should be submitted to the State fiscal agent for reimbursement.

In accordance with 42 CFR 438.102, the Contractor must not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a member.

The Contractor must develop and maintain a website in an OMPP-approved format (compliant with Section 508 of the US Rehabilitation Act) to ensure compliance with existing accessibility guidelines for network and out-of-network providers. The website must be live and meet the requirements of this section on the effective date of the Contract. OMPP must pre-approve the Contractor's website information and graphic presentations. The Contractor may choose to develop a separate provider website or incorporate it into the home page of the member website. To minimize download and wait times, the website must avoid techniques or tools that require significant memory or disk resources or require special intervention on the user side to install plug-ins or additional software. The Contractor must date each web page, change the date with each revision and allow users print access to the information. The provider website may have secured information available to network providers but must, at a minimum, have the following information available to all providers:

- Contractor's contact information
- Provider Manual and forms
- All of Contractor's provider communication materials, organized online in a user-friendly, searchable format by communication type and topic

- A link to the State's preferred drug list
- Claim submission information such as, but not limited to: Contractor submission and processing requirements, paper and electronic submission procedures, emergency room auto-pay lists and frequently asked questions
- Provider claims dispute resolution procedures for contracted and out-of-network providers
- Prior authorization procedures, including a complete list of services which require prior authorization
- Appeal procedures
- Entire network provider listings
- Links to OMPP's website for general Medicaid, Hoosier Healthwise or HIP information
- HIPAA Privacy Policy and Procedures

The Contractor must maintain a toll-free telephone helpline for all providers with questions, concerns or complaints. With the exception of the holidays listed below, the Contractor must staff the telephone provider helpline with personnel trained to accurately address provider issues during (at a minimum) a twelve (12)-hour business day, from 7 a.m. to 7 p.m. Eastern, Monday through Friday. The provider helpline may be closed on the following holidays:

- New Year's Day
- Memorial Day
- Independence Day (July 4th)
- Labor Day
- Thanksgiving
- Christmas

The Contractor may request that additional days, such as the day before Thanksgiving, be authorized for limited staff attendance. This request must be submitted to OMPP at least thirty (30) calendar days in advance of the date being requested for limited staff attendance and must be approved by OMPP. For all days with a closure, early closing or limited staff attendance, there shall be a process for providers to process emergency prior authorizations as needed. Call center closures, limited staffing or early closures shall not burden a member's access to care.

The Contractor must maintain a system for tracking and reporting the number and type of provider calls and inquiries. The Contractor must monitor its provider helpline and report its telephone service performance to OMPP each quarter as described in the Contractor Reporting Manual, which shall be provided following the Contract award date.

The State fiscal agent sponsors workshops and seminars for all IHCP providers. The Contractor must participate in the workshops and attend the provider seminars. A Contractor representative must be available to make formal presentations and respond to questions during the scheduled time(s). The Contractor is also encouraged to set up an information booth with a representative available during the provider seminars.

7.9 Provider Payment Requirements

The Contractor shall develop policies and procedures to prohibit the payment of certain hospital acquired conditions and never events. These policies and procedures shall be submitted in the Bidder's response to the RFS and must be approved by OMPP prior to implementation.

The Contractor's policy on non-payment of certain hospital-acquired conditions must comply with 405 IAC 1-10.5-5 and the IHCP Provider Bulletin regarding Present on Admission Indicator for Hospital Acquired Conditions dated August 25, 2009 (BT200928), as well as any updates or amendments thereto. A copy of the IHCP Provider Bulletin #BT200928 is included in the Bidder's Library.

The Contractor's policy on non-payment of certain never events must be developed in accordance with current Medicare National Coverage Determinations (NCDs), as well as any Indiana Medicaid FFS rules or other guidance adopted or issued by OMPP at a future date.

7.10 Member Payment Liability

In accordance with 42 CFR 438.106, the Contractor and its subcontractors must provide that members are not held liable for any of the following:

- Any payments for covered services furnished under a contract, referral or other arrangement, to the extent that those payments are in excess of the amount that the member would owe if the Contractor provided the services directly
- Covered services provided to the member for which OMPP does not pay the Contractor
- Covered services provided to the member for which OMPP or the Contractor does not pay the provider that furnishes the services under a contractual, referral or other arrangement
- The Contractor's debts or subcontractor's debts, in the event of the entity's insolvency

The Contractor must ensure that its providers do not balance bill its members, i.e., charge the member for covered services above the amount paid to the provider by the Contractor. If the Contractor is aware that an out-of-network, non-IHCP provider, such as an out-of-state emergency services provider, is balance billing a member, the Contractor shall instruct the provider to stop billing the member and to enroll in the IHCP in order to receive reimbursement from the Contractor. The Contractor shall also contact the member to help resolve issues related to the billing.

IHCP providers are prohibited from charging a member, or the family of the member, for any amount not paid as billed for a covered IHCP service. Provider acceptance of payment from the

Contractor as payment in full is a condition of participation in the IHCP. An IHCP provider can bill a member only when the following conditions have been met:

- The service rendered must be determined to be non-covered by the IHCP.
- The member has exceeded the program limitations for a particular service.
- The member must understand, before receiving the service, that the service is not covered under the IHCP, and that the member is responsible for the charges associated with the service.
- The provider must maintain documentation that the member voluntarily chose to receive the service, knowing that the IHCP did not cover the service. A generic consent form is not acceptable unless it identifies the specific procedure to be performed, and the member signs the consent before receiving the service. See the IHCP Provider Manual for more information.

In cases where prior authorization is denied, a provider can bill a member for covered services if certain safeguards are in place and followed by the provider. The Contractor must establish, communicate and monitor compliance with these procedures, which must include at least the following:

- The provider must establish that authorization has been requested and denied prior to rendering the service;
- The provider has an opportunity to request review of the authorization decision by the Contractor. The Contractor must inform providers of the contact person, the means for contact, the information required to complete the review and the procedures for expedited review if necessary;
- If the Contractor maintains the decision to deny authorization, the provider must inform the member that the service requires authorization, and that authorization has been denied—if the provider is an out-of-network provider, the provider must also explain that covered services may be available without cost in-network if authorization is provided;
- The member must be informed of the right to contact the Contractor to file an appeal if the member disagrees with the decision to deny authorization;
- The provider must inform the member of member responsibility for payment if the member chooses to or insists on receiving the services without authorization;
- If the provider chooses to use a waiver to establish member responsibility for payment, use of such a waiver must meet the following requirements:
    - The waiver is signed only after the member receives the appropriate notification.
    - The waiver does not contain any language or condition to the effect that if authorization is denied, the member is responsible for payment.

  - Providers must not use non-specific patient waivers. A waiver must be obtained for each encounter or patient visit that falls under the scenario of non-covered services.
  - The waiver must specify the date the services are provided and the services that fall under the waiver's application.

- The provider must have the right to appeal any denial of payment by the Contractor for denial of authorization.

POWER Account funds shall not be used to provide a member payment that is permissible under this section.

7.10.1 Member Payment Liability – HIP

This section should not be interpreted as interfering with a provider's ability to hold members liable for the emergency services co-payment or payment of covered services with POWER Account funds before the member's deductible has been met. However, if the Contractor permits providers to bill members for services that require authorization, but for which authorization is denied, as outlined above, POWER Account funds shall not be used to reimburse the provider for the non-covered service.

7.11 Provider Directory

The Contractor must develop a provider directory. A printed copy of the provider directory must also be available to members and OMPP upon request. The Contractor may use the same provider directory for its Hoosier Healthwise and HIP populations, so long as the directory clearly designates which population(s) the provider serves.

The provider directory shall include the following information:

- Lists of PMPs, the PMPs' service locations (including county), phone numbers, office hours, type of PMP (i.e., family practice, general practitioners, general internists, general pediatricians, obstetricians and gynecologists, and internal medicine physicians specializing in pediatrics or endocrinology) and whether the PMPs are accepting new members

- Lists of specialty providers (including behavioral health providers and community mental health centers), their service locations (including county), phone numbers, office hours, type of specialty

- Lists of hospital providers, home care providers and all other network providers

- Languages spoken by the provider or the provider's office personnel

The Contractor must include the aforementioned provider network information in an OMPP-approved format (compliant with Section 508 of the US Rehabilitation Act) on its member website. The Contractor must list provider network information by county on the Contractor's website and update the information every two (2) weeks. Network provider information must be available to print from a remote user location.

8.0 Quality Management and Utilization Management

The Contractor must monitor, evaluate and take effective action to identify and address any needed improvements in the quality of care delivered to members in the Hoosier Healthwise and HIP programs by all providers in all types of settings, in accordance with the provisions set forth in this Scope of Work. In compliance with state and federal regulations, the Contractor must submit quality improvement data, including data that meets HEDIS standards for reporting and measuring outcomes, to OMPP that includes the status and results of performance improvement projects. Additionally, the Contractor must submit information requested by OMPP to complete the State's Annual Quality Assessment and Improvement Strategies Report to CMS.

8.1 Quality Management and Improvement Program

The Contractor's Medical Director must be responsible for the coordination and implementation of the Quality Management and Improvement Program. The program must have objectives that are measurable, realistic and supported by consensus among the Contractor's medical and quality improvement staff. Through the Quality Management and Improvement Program, the Contractor must have ongoing comprehensive quality assessment and performance improvement activities aimed at improving the delivery of health care services to members. As a key component of its Quality Management and Improvement Program, the Contractor will develop incentive programs for both providers and members, with the ultimate goal of encouraging appropriate utilization of health care resources and improving health outcomes of Hoosier Healthwise and HIP members. The Contractor may establish different provider and member incentives for its Hoosier Healthwise and HIP populations.

As a part of the Contractor's Quality Management and Improvement Program, the Contractor shall participate in OMPP's annual performance improvement program.

The Contractor must meet the requirements of 42 CFR 438 subpart D and the National Committee for Quality Assurance (NCQA), including but not limited to the requirements listed below, in developing its Quality Management and Improvement Program and the Quality Management and Improvement Work Plan. In doing so, it shall include an assessment of quality and appropriateness of care provided to members with special needs, complete performance improvement projects in a reasonable time so as to allow information about the success of performance improvement projects to be incorporated into subsequent quality improvement projects, and produce quality of care reports at least annually.

The Contractor's Quality Management and Improvement Program must:

- Include developing and maintaining an annual Quality Management and Improvement Work Plan which sets goals, establishes specific objectives, identifies the strategies and activities to undertake, monitors results and assesses progress toward the goals.

- Have in effect mechanisms to detect both underutilization and overutilization of services. The activities the Contractor takes to address underutilization and overutilization must be documented.

- Have written policies and procedures for quality improvement. Policies and procedures must include methods, timelines and individuals responsible for completing each task.

- Incorporate an internal system for monitoring services, including data collection and management for clinical studies, internal quality improvement activities, assessment of special needs populations and other quality improvement activities requested by OMPP.

- Participate appropriately in clinical studies, and use Health Plan Employer Data and Information Set® (HEDIS®) rate data and data from other similar sources to periodically and regularly assess the quality and appropriateness of care provided to members. In assessing the quality and appropriateness of care provided to Hoosier Healthwise members, the Contractor must act in accordance with EPSDT/Health Watch requirements.

- Collect measurement indicator data related to areas of clinical priority and quality of care. OMPP will establish areas of clinical priority and indicators of care. These areas may vary from one year to the next and from program to program. The areas will reflect the needs of the Hoosier Healthwise and HIP populations. Examples of areas of clinical priority include:

  - Behavioral health and physical health care coordination
  - Immunization rates
  - Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services (for Hoosier Healthwise only)
  - Prenatal care (for Hoosier Healthwise only)
  - Blood lead testing (for Hoosier Healthwise only)
  - Emergency room utilization
  - Access to care
  - Special needs care coordination and utilization
  - Asthma
  - Obesity, especially childhood obesity
  - Smoking cessation, especially for pregnant women
  - Inpatient and emergency department cardiac care follow-up and cardiac rehabilitation
  - Timely follow-up and notification of results from preventive care and/or biopsies
  - Integrated medical and behavioral health utilization

- Report any national performance measures developed by CMS in the future. The Contractor must develop an approach for meeting the desired performance levels established by CMS upon release of the national performance measures, in accordance with 42 CFR 438.240(a)(2).

- Have procedures for collecting and assuring accuracy, validity and reliability of performance outcome rates that are consistent with protocols developed in the public or private sector. The CMS website contains an example of available protocols.

- Develop and maintain a physician pay-for-performance program.

- Develop a member incentive program to encourage members to be personally accountable for their own health care and health outcomes. Targeted areas of performance could include the appropriate use of emergency room services, keeping appointments and scheduling appointments for routine and preventive services such as prenatal care, disease screenings, compliance with behavioral health drug therapy, compliance with diabetes treatment and well-child visits.

- Participate in any state-sponsored prenatal care coordination programs.

- Contract for an NCQA-accredited HEDIS audit and report audited HEDIS rates. A separate HEDIS audit is required for the Contractor's Hoosier Healthwise and HIP lines of business. The HEDIS audit and report must be based upon the NCQA methodology for sampling of HEDIS data.

- Conduct a Consumer Assessment of Health Plans (CAHPS) survey and report survey results to OMPP annually. A separate CAHPS survey is required for the Contractor's Hoosier Healthwise and HIP lines of business. The CAHPS survey must be based upon the NCQA methodology for sampling of CAHPS data.

- Participate in other quality improvement activities to be determined by OMPP.

8.1.1 Quality Management and Improvement Committee

The Contractor must establish an internal Quality Management and Improvement Committee to develop, approve, monitor and evaluate the Quality Management and Improvement Program and Work Plan. The same committee shall be responsible for both the Contractor's Hoosier Healthwise and HIP lines of business. The Contractor's Medical Director must be an active participant in the Contractor's internal Quality Management and Improvement Committee. The committee must be representative of management staff, Contractor departments and community partners, advocates, members and subcontractors, as appropriate. Subcontractors providing direct services to members must be represented on the committee.

The Contractor must have appropriate personnel attend and participate in OMPP's regularly scheduled Quality Strategy Committee meetings. The Contractor is encouraged to recommend attendees to Quality Strategy Committee meetings. Additionally, the Medical Director must attend and participate in OMPP's Quality Strategy Committee meetings at least quarterly to update OMPP and report on the Contractor's quality management and improvement activities and outcomes.

The Contractor must have a structure in place (e.g., other committees, sub-committees, work groups, task forces) that is incorporated into, and formally supports, the Contractor's internal Quality Management and Improvement Committee and Quality Management and Improvement Work Plan. All functional units in the Contractor's organizational structure must integrate their performance measures, operational activities and outcome assessments with the Contractor's internal quality management and improvement committee to support the Contractor's quality management and improvement goals and objectives.

8.1.2 Quality Management and Improvement Work Plan Requirements

The Contractor's Quality Management and Improvement Committee, in collaboration with the Contractor's Medical Director, must develop an annual Quality Management and Improvement Work Plan. The plan must identify the Contractor's quality management goals and objectives and include a timeline of activities and assessments of progress towards meeting the goals. One plan may be developed for both the Contractor's Hoosier Healthwise

and HIP lines of business, but the plan must include sections that are specific to each program. The plan must meet the HEDIS standards for reporting and measuring outcomes.

The Contractor must submit its Quality Management and Improvement Work Plan to OMPP during the readiness review and annually thereafter. The Contractor shall provide progress reports to OMPP on no less than a quarterly basis. The Contractor must be prepared to periodically report on its quality management activities to OMPP's Quality Strategy Committee.

The Contractor Reporting Manual, which shall be provided following the Contract award date, contains more information regarding the annual Quality Management and Improvement Work Plan.

8.1.3 External Quality Review

Pursuant to federal regulation, the State must arrange for an annual, external independent review of each Contractor's quality of, timeliness of and access to health care services. The Contractor's Quality Management and Improvement Program should incorporate and address findings from these external quality reviews.

8.2 Incentive Programs

OMPP will require Contractors to participate in a pay for performance program that focuses on rewarding Contractors' efforts to improve quality and outcomes for Hoosier Healthwise and HIP members. OMPP will provide, at minimum, financial performance incentives to Contractors based on performance targets in priority areas established by the State. The Contractor incentives and performance targets will be set forth in Attachment B to the Contract.

OMPP reserves the right to revise measures on an annual basis and will notify the Contractor of changes to incentive measures. The measures for 2011 will target the following services:

- Preventive care
- Pregnancy
- Well care
- Chronic disease care
- Emergency and inpatient utilization

The Contractor earning financial incentives as identified in this section must reinvest at least fifty percent (50%) of any bonus payments earned, as determined by OMPP, in provider incentives and/or enhanced member incentive programs. At least a portion of the provider and/or member incentives must be related to one of the State's identified quality goals. After OMPP announces the award, but before OMPP distributes the award, the Contractor must submit to OMPP its proposal for reinvesting fifty percent (50%) of the bonus amount.

Additional conditions to payment of incentive amounts is provided in Attachment B to the Contract.

8.2.1 Provider Incentive Programs

Contractors must establish a performance-based incentive system for its providers. Different provider incentives may be established for the Contractor's Hoosier Healthwise and HIP providers. The Contractor will determine its own methodology for incenting providers. The Contractor must obtain OMPP-approval prior to implementing its provider incentive program and before making any changes thereto. The State encourages creativity in designing pay for performance programs.

If the Contractor offers financial incentives to providers, these payments must be above and beyond the standard Medicaid fee-for-service fee schedule (for Hoosier Healthwise) and Medicare fee schedule (for HIP).

Section 1876(i)(8) of the Social Security Act and federal regulations 42 CFR 438.6(n), 42 CFR 422.208 and 42 CFR 422.210 provide information regarding physician incentive plans. The Contractor must comply with all federal regulations regarding the physician incentive plan and supply to OMPP information on its plan as required in the regulations and with sufficient detail to permit OMPP to determine whether the incentive plan complies with the federal requirements. The Contractor must provide information concerning its physician incentive plan, upon request, to its members and in any marketing materials in accordance with the disclosure requirements stipulated in the federal regulations. Similar requirements apply to subcontracting arrangements with physician groups and intermediate entities.

Physician incentive plans must comply with the following requirements:

- The Contractor will make no specific payment directly or indirectly to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual member; and

- The Contractor meets requirements for stop-loss protection, member survey and disclosure requirements under 42 CFR 438.6(n).

8.2.2 Member Incentive Programs

Contractors must establish member incentive programs to encourage appropriate utilization of health services and healthy behaviors. Member incentives may be financial or non-financial. The Contractor will determine its own methodology for incenting members. For example, the Contractor may offer member incentives for:

- Attending all prenatal visits (Hoosier Healthwise only)
- Obtaining recommended preventive care
- Completing the expected number of EPSDT visits (Hoosier Healthwise only)
- Complying with treatment in a disease management, case management or care management program
- Making healthy lifestyle decisions such as quitting smoking or losing weight
- Completing a health screening

Except as provided herein, the Contractor may not offer gifts or incentives greater than $10.00 for each individual and $50.00 per year per individual. The Contractor may petition

OMPP, in the manner prescribed by OMPP, for authorization to offer items or incentives greater than $10.00 for each individual and $50.00 per year per individual if the items are intended to promote the delivery of certain preventive care services, as defined in 42 CFR 1003.101. Such incentives may not be disproportionate to the value of the preventive care service provided, as determined by OMPP. Petitions to provide enhanced incentives for preventive care shall be reviewed on a case-by-case basis, and OMPP shall retain full discretion in determining whether the enhanced incentives will be approved.

In any member incentive program, the incentives must be tied to appropriate utilization of health services and/or health-promoting behavior. For example, the member incentive programs can encourage responsible emergency room use or preventive care utilization. Contractors should develop member incentives designed to encourage appropriate utilization of health care services, increase adherence to keeping medical appointments and encourage the receipt of health care services in the appropriate treatment setting. Additionally, the Contractor must comply with all marketing provisions in the 42 CFR 438.104, as well as federal and state regulations regarding inducements. Examples of appropriate rewards include:

- Gift certificates for groceries
- Phone cards
- Gifts such as diaper bags or new baby "welcome" kits (Hoosier Healthwise only)

The Contractor must obtain OMPP-approval prior to implementing its member incentive program and before making any changes thereto.

8.2.3 Notification of Pregnancy (NOP) Incentives

OMPP has implemented a Notification of Pregnancy (NOP) process that encourages MCOs and providers to complete a comprehensive risk assessment (i.e., a NOP form) for pregnant members. NOP requirements and conditions for payment are set forth in the Managed Care Policies and Procedures Manual.

The NOP form must be submitted by providers via WebInterchange within five (5) calendar days of the visit during which the NOP form was completed. The State shall reimburse the Contractor for NOP forms submitted according to the standards set forth in the Managed Care Policies and Procedures Manual. This reimbursement amount must be passed on to the provider who completed the NOP form. An additional amount will be transferred to a bonus pool. The Contractor shall be eligible to receive bonus pool funds based on achievement of certain maternity-related targets See Attachment B for further detail regarding the NOP incentives and maternity-related targets.

The Contractor must have systems and procedures in place to accept NOP data from the State's fiscal agent, assign pregnant members to a risk level and, when indicated based on the member's assessment and risk level, enroll the member in a prenatal case management program. The Contractor shall assign pregnant members to a risk level and enter the risk level information into WebInterchange within twelve (12) calendar days of receiving NOP data from the State's fiscal agent.

8.3 Utilization Management Program

The Contractor must operate and maintain its own utilization management program. The Contractor may place appropriate limits on coverage on the basis of medical necessity or utilization control criteria, provided the services furnished can reasonably be expected to achieve their purpose. The Contractor is prohibited from arbitrarily denying or reducing the amount, duration or scope of required services solely because of diagnosis, type of illness or condition.

The Contractor must establish and maintain medical management criteria and practice guidelines in accordance with state and federal regulations that are based on valid and reliable clinical evidence or consensus among clinical professionals and consider the needs of the Contractor's members. Pursuant to 42 CFR 438.210(b), the Contractor must consult with contracting health care professionals in developing practice guidelines and must have mechanisms in place to ensure consistent application of review criteria for authorization decisions and consult with the provider that requested the services when appropriate. The Contractor must have sufficient staff with clinical expertise and training to interpret and apply the utilization management criteria and practice guidelines to providers' requests for health care or service authorizations for the Contractor's members. The Contractor must periodically review and update the guidelines, distribute the guidelines to providers and make the guidelines available to members upon request. Utilization management staff must receive ongoing training regarding interpretation and application of the utilization management guidelines. The Contractor must be prepared to provide a written training plan, which shall include dates and subject matter, as well as training materials, upon request by OMPP.

The State reserves the right to standardize certain parts of the prior authorization reporting process across the MCOs, such as requiring the MCOs to adopt and apply the same definitions regarding pended, denied, suspended claims, etc. When adopted, these standards shall be set forth in the Contractor Reporting Manual. The Contractor Reporting Manual will be provided following the Contract award date.

The Contractor's utilization management program policies and procedures must meet all NCQA standards and must include appropriate timeframes for:

- Completing initial requests for prior authorization of services
- Completing initial determinations of medical necessity
- Completing provider and member appeals and expedited appeals for prior authorization of service requests or determinations of medical necessity, per state law
- Notifying providers and members in writing of the Contractor's decisions on initial prior authorization requests and determinations of medical necessity
- Notifying providers and members of the Contractor's decisions on appeals and expedited appeals of prior authorization requests and determinations of medical necessity

The Contractor must report its medical necessity determination decisions, and must describe its prior authorization and emergency room utilization management processes to OMPP. When the Contractor conducts a prudent layperson review to determine whether an emergency medical

condition exists, the reviewer must not have more than a high school education and must not have training in a medical, nursing or social work-related field. The Contractor Reporting Manual, which shall be provided following the Contract award date, provides information on utilization reporting.

The Contractor's utilization management program shall not be limited to traditional utilization management activities, such as prior authorization. The Contractor must maintain a utilization management program that integrates with other functional units as appropriate and supports the Quality Management and Improvement Program. The utilization management program must have policies and procedures and systems in place to assist utilization management staff to identify instances of over- and under-utilization of emergency room services and other health care services, identify aberrant provider practice patterns (especially related to emergency room, inpatient services, transportation (for Hoosier Healthwise only), drug utilization, preventive care and screening exams), ensure active participation of a utilization review committee, evaluate efficiency and appropriateness of service delivery, incorporate subcontractor's performance data, facilitate program management and long-term quality and identify critical quality of care issues.

The Contractor's utilization management program must link members to disease management, case management and care management, as set forth in Section 5.8. The Contractor's utilization management program must also encourage health literacy and informed, responsible medical decision making. For example, Contractors should develop member incentives designed to encourage appropriate utilization of health care services, increase adherence to keeping medical appointments and obtain services in the appropriate treatment setting. Contractors shall also be responsible for identifying and addressing social barriers which may inhibit a member's ability to obtain preventive care.

The Contractor shall monitor utilization through retrospective reviews and will identify areas of high and low utilization and identify key reasons for the utilization patterns. The Contractor must identify those members that are high utilizers of emergency room services and/or other services and perform the necessary outreach and screening to assure the member's services are coordinated and that the member is aware of and participating in the appropriate disease management, case management or care management services. The Contractor must also use this data to identify additional disease management programs that are needed. Any member with emergency room utilization at least three (3) standard deviations outside of the mean for the population group must be referred to case management or care management. The Contractor may use the Right Choices Program (RCP), as described in Section 8.3.1 below, in identifying members to refer to case management or care management.

Although Contractors are not responsible for paying or reimbursing most pharmacy services, Contractors must monitor pharmacy utilization as identified in Section 5.4.

As part of its utilization review, the Contractor should monitor access to preventive care, specifically to identify members who are not accessing preventive care services in accordance with accepted preventive care standards such as those published by the American Academy of Pediatrics and the American College of Obstetrics and Gynecology (for Hoosier Healthwise) and OMPP's recommended preventive care guidelines (for HIP). The Contractor must develop education, incentives and outreach plans tailored to its member population to increase member compliance with preventive care standards.

In order to monitor potential under- or over-utilization of behavioral health services, OMPP requires Contractors to provide separate utilization reports for behavioral health services. The Contractor must particularly monitor use of services for its members with special needs and members with a diagnosis of severe mental illness or substance abuse.

8.3.1 The Right Choices Program (RCP)

The Right Choices Program (RCP) is Indiana's Restricted Card Program. The purpose of the RCP is to identify members who use covered services more extensively than their peers. The program, set forth in 405 IAC 1-1-2(c) and 405 IAC 5-6, is designed to monitor member utilization, and when appropriate, implement restrictions for those members who would benefit from increased care coordination. Program policies, set forth by the OMPP for the RCP, are delineated in the Right Choices Program Policy Manual. The Contractor shall comply with the program policies set forth in the Right Choices Program Policy Manual.

The Contractor shall be responsible for RCP duties, as outlined in the Right Choices Program Policy Manual, including, but not limited to, the following:

- Evaluate claims, medical information, referrals and data to identify members to be enrolled in the RCP— before enrolling a member in the RCP, the Contractor must ensure a physician, pharmacist or nurse confirms the appropriateness of the enrollment;
- Enroll members in the RCP;
- Provide written notification of RCP status to such members and their assigned primary physicians, pharmacies and/or hospitals;
- Intervene in the care provided to RCP members by providing, at minimum, enhanced education, case management and care coordination with the goal of modifying member behavior;
- Provide appropriate customer service to providers and members;
- Evaluate and monitor the member's compliance with his or her treatment plan to determine if the RCP restrictions should terminate or continue—the State shall make available utilization data about the Contractor's RCP members to assist the Contractor in its monitoring duties;
- Notify OMPP of members that are being reported to the FSSA Bureau of Investigation for suspected or alleged fraudulent activities;
- Provide ad-hoc reports about RCP to OMPP upon request;
- Cooperate with OMPP in evaluation activities of the program by providing data and/or feedback when requested by OMPP;
- Meet with OMPP about RCP program implementation as requested by OMPP; and

- Develop, obtain OMPP approval of and implement internal policies and procedures regarding the Contractor's RCP program administration.

OMPP shall monitor the Contractor's compliance with the RCP duties set forth in this Scope of Work and the Right Choices Program Policy Manual through its monthly onsite visits and/or external quality review activities. The Contractor may be subject to the non-compliance remedies as set forth in Attachment B to the Contract if the Contractor fails to comply with the RCP duties set forth in this Scope of Work and the Right Choices Program Policy Manual. OMPP reserves the right to review pharmacy and emergency room utilization figures for the Contractor's RCP membership, including the number of RCP members who have had more than one emergency room visit in a thirty (30)-calendar day period, in assessing the effectiveness of the Contractor's RCP program administration.

8.3.2 Authorization of Services and Notices of Actions

Clinical professionals who have appropriate clinical expertise in the treatment of a member's condition or disease must make all decisions to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested. Only ~~Indiana~~ licensed physicians and nurses may deny a service authorization request or authorize a service in an amount, duration or scope that is less than requested. The Contractor must not provide incentives to utilization management staff or to providers for denying, limiting or discontinuing medically necessary services. OMPP may audit Contractor denials, appeals and authorization requests. OMPP may waive certain administrative requirements, including prior authorization procedures, to the extent that such waivers are allowed by law and are consistent with policy objectives. The Contractor may be required to comply with such waivers and will be provided with prior notice by OMPP. If the Contractor delegates some or all of its prior authorization function to subcontractors, the Contractor must conduct annual audits and ongoing monitoring to ensure the subcontractor's performance complies with the Contract, the Contractor's policies and procedures and state and federal law.

As part of the utilization management function, the Contractor must facilitate PMPs' requests for authorization for primary and preventive care services and must assist the PMP in providing appropriate referral for specialty services by locating resources for appropriate referral. In accordance with federal regulations, the process for authorization of services must comply with the following requirements:

- Second Opinions: In accordance with 42 CFR 438.206(b)(3), the Contractor must comply with all member requests for a second opinion from a qualified professional. If the provider network does not include a provider who is qualified to give a second opinion, the Contractor must arrange for the member to obtain a second opinion from a provider outside the network, at no cost to the member.

- Special Needs: In accordance with 42 CFR 438.208(c), the Contractor must allow members with special needs, who are determined to need a course of treatment or regular care monitoring, to directly access a specialist for treatment via an established mechanism such as a standing referral from the member's PMP or an approved number of visits. Treatment provided by the specialist must be appropriate for the member's condition and identified needs.

- Women's Health: In accordance with 42 CFR 438.206(b)(2), the Contractor must provide female members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the female member's designated source of primary care if that source is not a woman's health specialist. The Contractor must have an established mechanism to permit a female member direct access such as a standing referral from the member's PMP or an approved number of visits. The Contractor may also establish claims processing procedures that allow payment for certain women's health codes without prior authorization or referral.

The Contractor must track all prior authorization requests in their information system. All notes in the Contractor's prior authorization tracking system must be signed by clinical staff and include the appropriate suffix (e.g., RN, MD, etc.). For prior authorization approvals, the Contractor shall provide a prior authorization number to the requesting provider and maintain a record of the following information, at a minimum, in the Contractor's information system:

- Name of caller
- Title of caller
- Date and time of call
- Prior authorization number

For all denials of prior authorization requests, the Contractor shall maintain a record of the following information, at a minimum, in the Contractor's information system:

- Name of caller
- Title of caller
- Date and time of call
- Clinical synopsis inclusive of: 1) timeframe of illness or condition; 2) diagnosis; and 3) treatment plan
- Clinical guideline(s) or other rational supporting the denial (e.g., insufficient documentation)

The Contractor must provide a written notice to the member and provider of any decision to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested. The notice must meet the requirements of 42 CFR 438.404. The notice to members must be provided at a fifth grade reading level. The notice must be given within the timeframes described in the following paragraphs and 42 CFR 438.404(c).

The notification letters used by the Contractor must be approved by OMPP prior to use and clearly explain the following:

- The action the Contractor or its contractor has taken or intends to take

- The reasons for the action
- The member's right to file an appeal with the Contractor and the process for doing so
- After the member has exhausted the Contractor's appeal process, the notice must contain the member's right to request an FSSA Fair Hearing and the process for doing so
- Circumstances under which expedited resolution is available and how to request it
- The member's right to have benefits continue pending the resolution of the appeal, how to request continued benefits and the circumstances under which the member may have to pay the costs of these services

Unless otherwise provided in 405 IAC 5-3-14 (for Hoosier Healthwise) or 405 IAC 9-7-12 (for HIP), the Contractor must notify members of standard authorization decisions as expeditiously as required by the member's health condition, not to exceed seven (7) calendar days after the request for services. An extension of up to fourteen (14) calendar days is permitted if the member or provider requests an extension or if the Contractor justifies to OMPP a need for more information and explains how the extension is in the member's best interest. The Contractor will be required to provide its justification to OMPP upon request. Extensions require written notice to the member and must include the reason for the extension and the member's right to file a grievance.

Unless otherwise provided in 405 IAC 5-3-14 (Hoosier Healthwise) or 405 IAC 9-7-12 (HIP), if the Contractor fails to respond to a member's prior authorization request within seven (7) calendar days of receiving all necessary documentation, the authorization is deemed to be granted.

For situations in which a provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function, the Contractor must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than three (3) business days after receipt of the request for service. The Contractor may extend the three (3) business days by up to fourteen (14) calendar days if the member requests an extension or the Contractor justifies a need for additional information and how the extension is in the best interest of the member. The Contractor will be required to provide its justification to OMPP upon request.

The Contractor must notify members in writing of decisions to terminate, suspend or reduce previously authorized covered services at least ten (10) calendar days before the date of action, with the following exceptions:

- Notice is shortened to five (5) calendar days if probable member fraud has been verified by the Indiana Office of the Inspector General or Attorney General.
- Notice may occur no later than the date of the action in the event of:
  - The death of a member;

- The Contractor's receipt of a signed written statement from the member requesting service termination or giving information requiring termination or reduction of services (the member must understand the result of supplying this information;
- The member's admission to an institution and consequential ineligibility for further services;
- The member's address is unknown and mail directed to him/her has no forwarding address;
- The member's acceptance for Medicaid services by another local jurisdiction;
- The member's physician prescribes the change in the level of medical care;
- An adverse determination made with regard to the preadmission screening requirements for nursing facility admissions; or
- The safety or health of individuals in the facility would be endangered, the member's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the member's urgent medical needs or a member has not resided in the nursing facility for thirty (30) calendar days (applies only to adverse actions for nursing facility transfers).

8.3.3 Objection on Moral or Religious Grounds

If the Contractor elects not to provide, reimburse for or provide coverage of a counseling or referral service because of an objection on moral or religious grounds, it must furnish information about the services it does not cover as follows, in accordance with 42 CFR 438.102(b):

- To OMPP with its response to the RFS
- To OMPP if it adopts the policy during the term of the Contract
- To potential members before and during enrollment
- To members within ninety (90) calendar days after adopting the policy with respect to any particular service, but at least thirty (30) calendar days prior to the effective date

8.3.4 Utilization Management Committee

The Contractor must have an utilization management committee directed by the Contractor's Medical Director. The same committee shall be responsible for both the Contractor's Hoosier Healthwise and HIP lines of business. The committee is responsible for:

- Monitoring providers' requests for rendering health care services to its members
- Monitoring the medical appropriateness and necessity of health care services provided to its members

- Reviewing the effectiveness of the utilization review process and making changes to the process as needed

- Writing policies and procedures for utilization management that conform to industry standards including methods, timelines and individuals responsible for completing each task

- Confirming the Contractor has an effective mechanism in place for a plan provider or Contractor representative to respond within one hour to all emergency room providers twenty four (24)-hours-a-day, seven (7)-days-a-week:

  - After the Contractor's member's initial emergency room screening; and,

  - After the Contractor's member has been stabilized and the emergency room provider believes continued treatment is necessary to maintain stabilization.

8.4 Program Integrity Plan

Pursuant to 42 CFR 438.608, the Contractor must have an administrative procedure that includes a mandatory compliance plan that describes in detail the manner in which it will detect fraud and abuse. The Program Integrity Plan must be updated annually and submitted to OMPP. The Contractor may prepare one plan for both the Contractor's Hoosier Healthwise and HIP lines of business.

The Contractor must include the following in its Program Integrity Plan:

- Written policies, procedures and standards of conduct that articulate the organization's commitment to comply with all applicable state and federal standards.

- The designation of a Compliance Officer and a Compliance Committee that are accountable to senior management. The Compliance Officer shall meet with the State's Surveillance and Utilization Review Unit (SUR) Director on a quarterly basis.

- The type and frequency of training and education for the Compliance Officer and the organization's employees who will be provided to detect fraud. Training must be annual and address the False Claims Act, as directed by CMS.

- Effective lines of communication between the Compliance Officer and the organization's employees.

- Enforcement of standards through well-publicized disciplinary guidelines.

- Provision for internal monitoring and auditing.

- Provision for prompt response to detected offenses, and for development of corrective action initiatives.

- Program integrity-related goals, objectives and planned activities for the upcoming year.

On a quarterly basis, the Contractor shall submit a high-level progress report to OMPP which outlines the Contractor's program integrity-related activities and findings, as well as identifies the Contractor's progress in meeting program integrity-related goals and objectives. The quarterly progress report must also identify recoupment totals for the reporting period.

The Contractor must immediately report any suspicion or knowledge of fraud and abuse including, but not limited to the false or fraudulent filings of claims and the acceptance or failure to return monies allowed or paid on claims known to be fraudulent. The Contractor must report provider fraud to OMPP, the Indiana Medicaid Fraud Control Unit (IMFCU) and the Surveillance and Utilization Review Unit (SUR). The Contractor must report member fraud to OMPP, the SUR, the Indiana Bureau of Investigation and the Office of the Inspector General.

The Contractor must not attempt to investigate or resolve the reported suspicion, knowledge or action without informing the IMFCU and OMPP and must cooperate fully in any investigation by the IMFCU or subsequent legal action that may result from such an investigation.

If subsequent investigation or legal action results in a monetary recovery to OMPP, the reporting Contractor will be entitled to share in such recovery following final resolution of the matter (settlement agreement/final court judgment) and following payment of recovered funds to the State of Indiana. The Contractor's share of recovery will be as follows:

- From the recovery, the State (including the IMFCU) shall retain its costs of pursuing the action, and its actual documented loss (if any). The State will pay to the Contractor the remainder of the recovery, not to exceed the Contractor's actual documented loss. Actual documented loss of the parties will be determined by paid false or fraudulent claims, canceled checks or other similar documentation which objectively verifies the dollar amount of loss.

- If the State determines it is in its best interest to resolve the matter under a settlement agreement, the State has final authority concerning the offer, or acceptance, and terms of a settlement. The State will exercise its best efforts to consult with the Contractor about potential settlement. The State may consider the Contractor's preferences or opinions about acceptance, rejection or the terms of a settlement, but they are not binding on the State.

- If final resolution of a matter does not occur until after the Contract has expired, the preceding terms concerning disposition of any recovery and consultation with the Contractor shall survive expiration of the Contract and remain in effect until final resolution of a matter referred to the IMFCU by the Contractor under this section.

If the State makes a recovery in a matter where the Contractor has sustained a documented loss but the case did not result from a referral made by the Contractor, the recovery will be distributed in accordance with the terms of this section.

9.0 Information Systems

The Contractor must have an Information System (IS) sufficient to support the Hoosier Healthwise and HIP program requirements, and the Contractor must be prepared to submit all required data and reports in the format specified by OMPP. The Contractor must maintain an IS with capabilities to perform the data receipt, transmission, integration, management, assessment and system analysis tasks described in this Scope of Work. The Contractor's IS must integrate pharmacy data from the State

fiscal agent for utilization analysis, care management activities, POWER Account activities and annual and lifetime benefit calculations. OMPP will provide the Contractor with pharmacy claims data on the Contractor's members on a weekly basis through the State fiscal agent. OMPP will also provide access to real-time pharmacy profiles via a web portal.

In the event the State's technical requirements require amendment during the term of the Contract, the State will work with Contractors in establishing the new technical requirements. The Contractor must be capable of adapting to any new technical requirements established by the State, and the State may require the Contractor to agree in writing to the new requirements. After the Contractor has agreed in writing to a new technical requirement, any Contractor-initiated changes to the requirements shall require OMPP approval and OMPP may require the Contractor to pay for additional costs incurred by the State in implementing the Contractor-initiated change.

The Contractor must have a plan for creating, accessing, storing and transmitting health information data in a manner that is compliant with HIPAA standards for electronic exchange, privacy and security requirements (45 CFR 162 and 164).

The Secretary of the Department of Health and Human Services (HHS) has adopted ASC X12 version 5010 as the next HIPAA standard for HIPAA covered transactions. The final rule was published on January 16, 2009 and all covered entities must be fully compliant on January 1, 2012. Contractors must complete an internal gap analysis to compare their current systems against the 5010 standard. Completion of such analysis will be verified during the readiness review. The Contractor must be ready to begin testing in the 5010 format with the State's fiscal agent and other vendors on January 1, 2011. Readiness to test will be demonstrated during the readiness review process.

The Contractor's IS must support HIPAA Transaction and Code Set requirements for electronic health information data exchange, National Provider Identifier requirements and Privacy and Security Rule standards. The Contractor's electronic mail encryption software for HIPAA security purposes must be the same as the State's. The Contractor's IS plans for privacy and security shall include, but not be limited to:

- Administrative procedures and safeguards (45 CFR 164.308)
- Physical safeguards (45 CFR 164.310)
- Technical safeguards (45 CFR 164.312)

The Contractor must make data available to OMPP and, upon request, to CMS. In accordance with 42 CFR 438, subpart H, the Contractor must submit all data, including encounter claims, under the signatures of either its Financial Officer or Executive leadership (e.g., President, Chief Executive Office, Executive Director), certifying the accuracy, truthfulness and completeness of the Contractor's data. See the Contractor Reporting Manual, which shall be provided following the Contract award date, for the attestation form.

The Contractor must comply with all Indiana Office of Technology (IOT) standards, policies and guidelines, which are available online at http://in.gov/iot/2394.htm. All hardware, software and services provided to or purchased by the State shall be compatible with the principles and goals contained in the electronic and information accessibility standards adopted under Section 508 of the Federal Rehabilitation Act of 1973 (29 USC 794d) and IC 4-13.1-3. Any deviation from these architecture requirements must be approved in writing by IOT in advance.

9.1 Disaster Recovery Plans

Information system contingency planning shall be developed in accordance with 45 CFR 164.308. Contingency plans shall include: Data Backup plans, Disaster Recovery plans and Emergency Mode of Operation plans. Application and Data Criticality analysis and Testing and Revisions procedures must also be addressed. The Contractor must protect against hardware, software and human error. The Contractor must maintain appropriate checkpoint and restart capabilities and other features necessary to ensure reliability and recovery, including telecommunications reliability, file back-ups and disaster recovery. The Contractor must maintain full and complete back-up copies of data and software, and must back up on tape or optical disk and store its data in an off-site location approved by OMPP. The Contractor must maintain or otherwise arrange for an alternate site for its system operations in the event of a disaster.

For purposes of this Scope of Work, "disaster" means an occurrence of any kind that adversely affects, in whole or in part, the error-free and continuous operation of the Contractor's or its subcontracting entities' IS or affects the performance, functionality, efficiency, accessibility, reliability or security of the system. The Contractor must take the steps necessary to fully recover the data or system from the effects of a disaster and to reasonably minimize the recovery period. The State and the Contractor will jointly determine when unscheduled system downtime will be elevated to a "disaster" status. Disasters may include natural disasters, human error, computer virus or malfunctioning hardware or electrical supply.

The Contractor's responsibilities include, but are not limited to:

- Supporting immediate restoration and recovery of lost or corrupted data or software.

- Establishing and maintaining, in an electronic format, a weekly back-up and a daily back-up that are adequate and secure for all computer software and operating programs; database tables; files; and system, operations and user documentation.

- Demonstrating an ability to meet back-up requirements by submitting and maintaining Data Backup and Disaster Recovery Plans that address:

  - Checkpoint and restart capabilities and procedures
  - Retention and storage of back-up files and software
  - Hardware back-up for the servers
  - Hardware back-up for data entry equipment
  - Network back-up for telecommunications

- In the event of a catastrophic or natural disaster, resuming normal business functions at the earliest possible time, not to exceed thirty (30) calendar days. If deemed appropriate by the State, coordinating with the State fiscal agent to restore the processing of claims by Indiana*AIM* if the claims processing capacity cannot be restored within the Contractor's system.

- In the event of other disasters caused by such things as criminal acts, human error, malfunctioning equipment or electrical supply, resuming normal business functioning at the earliest possible time, not to exceed ten (10) calendar days.

- The Contractor must promptly notify OMPP of any disruptions in its normal business operations, and may be required to supply to OMPP a plan for resuming operations.

- Developing coordination methods for disaster recovery activities with OMPP and its contractors to ensure continuous eligibility, enrollment and delivery of services.

- Providing the State with business resumption documents, reviewed and updated at least annually, such as:

  - Disaster Recovery Plans
  - Business Continuity and Contingency Plans
  - Facility Plans
  - Other related documents as identified by the State

9.2 Member Enrollment Data Exchange

The Contractor is responsible for verifying member eligibility data and reconciling with capitation payments for each eligible member. The Contractor must reconcile its eligibility and capitation records monthly. For the Contractor's HIP members, the monthly reconciliation must also include a reconciliation with state POWER Account contributions received via the 820 transaction. If the Contractor discovers a discrepancy in eligibility, capitation or POWER Account payment information, the Contractor must notify OMPP and the State fiscal agent within thirty (30) calendar days of discovering the discrepancy and no more than ninety (90) calendar days after OMPP delivers the eligibility records. The Contractor must return any capitation or POWER Account overpayments to OMPP within forty-five (45) calendar days of discovering the discrepancy. The Managed Care Policies and Procedures Manual details the terms for reconciling eligibility and underpayments of capitation back to the Contractor. If the Contractor receives either enrollment information or capitation for a member, and/or a state POWER Account contribution for a HIP member, the Contractor is financially responsible for the member.

The Contractor must accept enrollment data in electronic format, currently via secure FTP, as directed by OMPP. The Companion Guide – 834 Contractor Benefit Enrollment and Maintenance Transaction details the enrollment data exchange. The Contractor is responsible for loading the eligibility information into its claims system within five (5) calendar days of receipt. See Companion Guide – 834 MCO Benefit Enrollment and Maintenance Transaction for more information regarding enrollment rosters.

The Contractor's information systems must accommodate the State's 12-digit recipient identification number (RID) for each member.

9.3 Provider Network Data

The Contractor must submit provider network information to the State fiscal agent via WebInterchange. The Contractor shall keep provider enrollment and disenrollment information up-to-date. The Contractor shall enter updates into WebInterchange no less frequently than on the 1st and 15th day of each month. For more information regarding provider network data, see Section 7 and the Managed Care Policies and Procedures Manual.

9.4 Claims Processing

9.4.1 Claims Processing Capability

The Contractor must demonstrate and maintain the capability to process and pay provider claims for services rendered to the Contractor's members, in compliance with HIPAA, including National Provider Identification (NPI). The Contractor must be able to price specific procedures or encounters (depending on the agreement between the provider(s) and the Contractor) and to maintain detailed records of remittances to providers. OMPP must pre-approve the Contractor's delegation of any claims processing function to a sub-contractor, and the Contractor must notify OMPP and secure OMPP's approval of any change to sub-contracting arrangements for claims processing.

The Contractor must develop policies and procedures to monitor claims adjudication accuracy and must submit its policies and procedures for monitoring its claims adjudication accuracy to OMPP for review and approval.

The out-of-network provider filing limit for submission of claims to the Contractor is twelve (12) months from the date of service. This conforms with the filing limit under the Medicaid state plan (42 CFR 447.45(d)(4)). The in-network provider filing limit is established in the Contractor's provider agreements pursuant to the guidelines set forth in Section 7.4, which generally require in-network providers to submit claims within three (3) months from the date of service.

9.4.2 Compliance with State and Federal Claims Processing Regulations

The Contractor must have a claims processing system to support electronic claims submission for both in- and out-of-network providers. The Contractor's system must process all claim types such as professional and institutional claims. The Contractor must comply with the claims processing standards and confidentiality standards under IC 12-15-13-1.6 and IC 12-15-13-1.7, and any applicable federal regulations, including HIPAA regulations related to the confidentiality and submission requirements for protected health information (PHI). The Contractor must ensure that communication with providers, particularly out-of-network providers, and submission requirements are efficient and not burdensome for any providers. The Contractor is prohibited from requiring out-of-network providers to establish a Contractor-specific provider number in order to receive payment for claims submitted.

9.4.3 Claims Payment Timelines

The Contractor must pay providers for covered medically necessary services rendered to the Contractor's members in accordance with the standards set forth in IC 12-15-13-1.6 and IC 12-15-13-1.7, unless the Contractor and provider agree to an alternate payment schedule and method. The Contractor must pay or deny electronically filed clean claims within twenty one (21) calendar days of receipt. A "clean claim" is one in which all information required for processing the claim is present. The Contractor must pay or deny clean paper claims within thirty (30) calendar days of receipt. If the Contractor fails to pay or deny a clean claim within these timeframes and subsequently reimburses for any services itemized within the claim, the Contractor must also pay the provider interest at the rate set forth in IC 12-15-21-3(7)(A). The Contractor must pay interest on all clean claims paid late (i.e., in- or out-of-network

claims) for which the Contractor is responsible, unless the Contractor and provider have made alternate written payment arrangements.

As provided in 42 CFR 447.46(c)(2), the Contractor may, by mutual agreement, establish an alternative payment schedule with in-network providers. The alternative payment schedule must be outlined in the provider contract. However, the alternate payment schedule must not violate the claims payment provisions and timeframes that apply to accident and sickness insurers and HMOs under IC 27-8-5.7 and IC 27-13-36.2.

OMPP reserves the right to perform a random sample audit of all claims, and expects the Contractor to fully comply with the requirements of the audit and provide all requested documentation, including provider claims and encounters submissions.

9.5 POWER Account Systems – HIP

The requirements in this section apply to the Contractor's HIP line of business only.

The Contractor must have an IS that is capable of automating the required POWER Account transactions, including the 820, 834 and PRF transactions, in compliance with the data specifications set forth in the State fiscal agent's Companion Guides. The Contractor must provide real-time access to member POWER Account balances in a secure format.

The Contractor must have policies, procedures and mechanisms in place to support the POWER Account requirements set forth in the Managed Care Policies and Procedures Manual and the State fiscal agent's Companion Guides. The Contractor must have polices, procedures and mechanisms in place to support accuracy, security and privacy in the Contractor's administration of member POWER Accounts.

9.6 Encounter Data Submission

The Contractor must have policies, procedures and mechanisms in place to support the encounter data reporting process described below and in the State fiscal agent's Companion Guides. The Contractor must strictly adhere to the standards set forth in the State fiscal agent's Companion Guides, such as the file structure and content definitions (including any content definitions as may further be interpreted or defined by OMPP).

The Contractor Technical Meeting provides a forum for Contractor technical support staff to participate in the development of the data exchange process and ask questions related to data exchange issues, including encounter data transmission and reporting issues. The Contractor must report any problems it is experiencing with encounter data submissions and reporting at this monthly meeting and to its designated OMPP Policy Analyst.

9.6.1 Definition and Uses of Encounter Data

The Contractor must submit an encounter claim to the State fiscal agent for every service rendered to a member for which the Contractor either paid or denied reimbursement. Encounter data provides reports of individual patient encounters with the Contractor's health care network. These claims contain fee-for-service equivalent detail as to procedures, diagnoses, place of service, units of service, billed amounts and rendering providers'

identification numbers and other detailed claims data required for quality improvement monitoring and utilization analysis.

The State will use the encounter data to make tactical and strategic decisions related to the Hoosier Healthwise and HIP program and to the Contract. **The State shall use only encounter data to calculate Contractor's future capitation rates.** It will also use encounter data to calculate incentive payments to the Contractor, monitor quality and to assess the Contractor's Contract compliance. See Attachment B of the Contract for a schedule of liquidated damages that OMPP will assess for non-compliance with encounter data submission requirements.

Submission of institutional encounter claims with the appropriate diagnosis and DRG codes generates a maternity delivery capitation payment for Hoosier Healthwise members. Refer to the Managed Care Policies and Procedures Manual for specific information.

9.6.2 Reporting Format and Batch Submission Schedule

The Contractor must submit institutional and professional encounter claims in an electronic format that adheres to the data specifications in the State fiscal agent's Companion Guides and any other state or federally mandated electronic claims submission standards or be subject to liquidated damages. **A diagnosis code and DRG, as applicable, is a required data field and must be included on all encounter claims.** An indication of claim payment status and an identification of claim type (i.e., original, void or replacement) is also required, in the form designated by the State fiscal agent. For HIP claims, the amount of POWER Account funds used to pay the claim must be designated on each encounter claim.

The Contractor must submit via secure FTP at least one batch of encounter data for paid and denied institutional and professional claims before 5 p.m. Eastern on Wednesday each week. OMPP will use an overall average of calendar month submissions to assess compliance with this encounter claim submission requirement. The State will require the Contractor to submit a corrective action plan and will assess liquidated damages for failure to comply with the encounter claims submission requirements. See Attachment B of the Contract for a schedule of liquidated damages OMPP will assess for non-compliance with this requirement.

9.6.3 Encounter Claims Quality

The Contractor must have written policies and procedures to address its submission of encounter claims to the State. At least annually, or on a schedule determined at the discretion of the State, the Contractor must submit an encounter claims work plan that addresses the Contractor's strategy for monitoring and improving encounter claims submission.

The Contractor shall comply with the following requirements:

- Timeliness of Contractor's Encounter Claims Submission to the State Fiscal Agent: The Contractor must submit all encounter claims within fifteen (15) months of the earliest date of service on the claim. The Contractor must submit void/replacement claims within two (2) years from the date of service. In addition, the Contractor must submit one hundred percent (100%) of adjudicated claims within thirty (30) calendar days of adjudication. The State will require the Contractor to submit a corrective action plan to

address timeliness issues and will assess liquidated damages if the Contractor fails to comply with pre-cycle edits.

- Compliance with Pre-cycle Edits: The State fiscal agent will assess each encounter claim for compliance with pre-cycle edits. The Contractor must correct and resubmit any encounter claims that do not pass the pre-cycle edits. The State will require the Contractor to submit a corrective action plan to address non-compliance issues and will assess liquidated damages if the Contractor fails to comply with pre-cycle edits.

- Accuracy of Encounter Claims Detail: The Contractor must demonstrate that it implements policies and procedures to ensure that encounter claims submissions are accurate; that is, that all encounter claims detail being submitted accurately represents the services provided and that the claims are accurately adjudicated according to the Contractor's internal standards and all state and federal requirements. OMPP reserves the right to monitor Contractor encounter claims for accuracy against the Contractor's internal criteria and its level of adjudication accuracy. OMPP will regularly monitor the Contractor's accuracy by reviewing the Contractor's compliance with its internal policies and procedures for ensuring accurate encounter claims submissions and by performing a random sample audit of all claims. OMPP expects the Contractor to fully comply with the requirements of the review and audit and to provide all requested documentation, including provider and encounter claims submissions and medical records. OMPP will require the Contractor to submit a corrective action plan and will require non-compliance remedies for the Contractor's failure to comply with shadow claims accuracy reporting standards.

- Completeness of Encounter Claims Data: The Contractor must have in place a system for monitoring and reporting the completeness of claims and encounter data received from providers, i.e., for every service provided, providers must submit corresponding claim or encounter data with claim detail identical to that required for fee-for-service claims submissions. The Contractor must also have in place a system for verifying and ensuring that providers are not submitting claims or encounter data for services that were not provided.

  As part of its annual encounter claims work plan, the Contractor must demonstrate its internal standards for measuring completeness, the results of any completeness studies, and any corrective action plans developed to address areas of non-compliance. OMPP may require the Contractor to demonstrate, through report or audit, that this monitoring system is in place and that the Contractor is regularly monitoring the completeness of claims and encounter data and ensuring that the Contractor is meeting OMPP's completeness requirements as described in the RFS.

  OMPP will require the Contractor to submit a corrective action plan and will require non-compliance remedies for the Contractor's failure to comply with encounter claims completeness reporting standards, as identified in the CRCS Report.

9.7 Third Party Liability (TPL) Issues

9.7.1 Coordination of Benefits

If a member is also enrolled in or covered by another insurer, the Contractor is fully responsible for coordinating benefits so as to maximize the utilization of third party coverage. The Contractor must share information regarding its members, especially those with special health care needs, with other payers as specified by OMPP and in accordance with 42 CFR 438.208(b). In the process of coordinating care, the Contractor must protect each member's privacy in accordance with the confidentiality requirements stated in 45 CFR 160 and 164. The Contractor is responsible for payment of the member's coinsurance, deductibles, co-payments and other cost-sharing expenses, but the Contractor's total liability must not exceed what the Contractor would have paid in the absence of TPL, after subtracting the amount paid by the primary payer.

The Contractor must coordinate benefits and payments with the other insurer for services authorized by the Contractor, but provided outside the Contractor's plan. Such authorization may occur prior to provision of service, but any authorization requirements imposed on the member or provider of service by the Contractor must not prevent or unduly delay a member from receiving medically necessary services. The Contractor remains responsible for the costs incurred by the member with respect to care and services which are included in the Contractor's capitation rate, but which are not covered or payable under the other insurer's plan.

In accordance with IC 12-15-8 and 405 IAC 1-1-15, OMPP has a lien upon any money payable by any third party who is or may be liable for the medical expenses of a Medicaid recipient when Medicaid provides medical assistance. The Contractor may exercise any independent subrogation rights it may have under Indiana law in pursuit or collection of payments it has made when a legal cause of action for damages is instituted by the member or on behalf of the member.

9.7.1.1 Coordination of Benefits – Hoosier Healthwise, Package A, B and P

If the Hoosier Healthwise member primary insurer is a commercial HMO and the Contractor cannot efficiently coordinate benefits because of conflicts between the primary HMO's rules and the Contractor's rules, the Contractor may submit to the Enrollment Broker a written request for disenrollment. The request must provide the specific description of the conflicts and explain why benefits cannot be coordinated. The Enrollment Broker will consult with OMPP and the request for disenrollment will be considered and acted upon accordingly.

9.7.1.2 Coordination of Benefits – HIP and Hoosier Healthwise, Package C (CHIP)

An individual is not eligible for HIP or Hoosier Healthwise Package C if they have other health insurance coverage. If the Contractor discovers that a HIP or Hoosier Healthwise Package C member has other health insurance coverage, they are not required to coordinate benefits but must report the member's coverage to the State. The Contractor shall assist the State in its efforts to terminate the member from HIP or Hoosier Healthwise Package C due to the existence of other health insurance.

The types of other insurance coverage the Contractor should coordinate with include insurance such as worker's compensation insurance and automobile insurance.

9.7.2 Collection and Reporting

The Contractor will be responsible for identifying, collecting and reporting third party liability coverage and collection information to the State. As third party liability information is a component of capitation rate development, the Contractor must maintain records regarding third party liability collections and report these collections to OMPP in the timeframe and format determined by OMPP.

9.7.2.1 Collection and Reporting – Hoosier Healthwise, Package A, B and P

The Contractor will retain all third party liability collections made on behalf of its Hoosier Healthwise members.

9.7.2.2 Collection and Reporting – HIP and Hoosier Healthwise, Package C

In the case of HIP, third party coverage deems the member ineligible for the program. The Contractor must complete the TPL form and return to the State.

The Contractor will retain all TPL collections from any insurer or responsible party other than health insurers (e.g., automobile insurers, workers compensation insurers, etc.). In an effort to incentivize Contractors to investigate whether members have obtained health insurance that would exclude them from HIP or Hoosier Healthwise Package C eligibility, Contractors may keep thirty percent (30%) of the recovery collected from other health insurers, but must transfer the remaining seventy percent (70%) to the State within thirty (30) calendar days of collection.

9.7.3 Cost Avoidance

The Contractor's TPL responsibilities include cost avoidance. When the Contractor is aware of other insurance coverage prior to paying for a health care service for a member, it should avoid payment by rejecting a provider's claim and direct that the provider first submit the claim to the appropriate third party. The Contractor will be allowed to keep some or all of the costs it recovers from the third party, as set forth in Section 9.7.2 above.

When it has identified members who have newly discovered health insurance, members who have changed coverage or members who have casualty insurance coverage, the Contractor will provide the State and its fiscal agent the following information:

- Member name/RID number/Social Security number
- Carrier name/address/phone number/contact person
- Policyholder name/address/Social Security number/relationship to member
- Policy number/effective date/coverage type

If insurance coverage information is not available, or if one of the exceptions to the cost avoidance rule discussed in this section applies, then the Contractor must make the payment and make a claim against the third party, if it is determined that the third party is or may be liable. The Contractor must ensure that its cost avoidance efforts do not prevent a member from receiving medically necessary services in a timely manner.

9.7.4 Cost Avoidance Exceptions

Cost avoidance exceptions in accordance with 42 CFR 433.139 include the following situations in which the Contractor must first pay the provider and then coordinate with the liable third party:

- The claim is for prenatal care for a pregnant woman (Hoosier Healthwise only)
- The claim is for labor, delivery and post-partum care, and does not involve hospital costs associated with the inpatient hospital stay (Hoosier Healthwise only)
- The claim is for preventive pediatric services (including EPSDT) that are covered by the Medicaid program
- The claim is for coverage derived from a parent whose obligation to pay support is being enforced by the State Title IV-D Agency and the provider of service has not received payment from the third party within thirty (30) calendar days after the date of service
- The claim is for services provided that were covered by a third party at the time services were rendered or reimbursed (i.e., the Contractor was not aware of the third party coverage); the Contractor must pursue reimbursement from potentially liable third parties.

9.8 Health Information Technology and Data Sharing

The use of Health Information Technology (HIT) has the potential to improve the quality and efficiency of health care delivery in numerous ways. Digitizing and sharing health care data can reduce medical errors, increase efficiency, decrease duplicative or unnecessary services and reduce fraud and abuse. Additionally, HIT initiatives are important in improving the data quality necessary for public health research, evidenced-based decision-making, population health management and reduction of manual, labor-intensive monitoring and oversight.

Contractors should develop, implement and participate in health care information technology (HIT) and data sharing initiatives in order to improve the quality, efficiency and safety of health care delivery in Indiana.

Contractors shall be required to enter into data sharing agreements with any health information technology entity that the State enters into data sharing agreements with.

OMPP reserves the right to require Contractors to establish personal health records (PHRs) for its members in the future. A PHR is an electronic health record of the member that is maintained by the Contractor. PHRs typically include a summary of member health and medical history such as diagnoses, allergies, family history, lab results, vaccinations, surgeries, etc., and may also include

claims information. In the event the State adopts a standard PHR format, the Contractor shall be required to implement the State's standard format. The Contractor shall also be required to incorporate its member portal information and, for HIP members, POWER Account balance information into the PHR.

In addition to a PHR, the following are examples of other types of HIT initiatives that the Contractor may consider developing:

- **Electronic prescribing (e-prescribing).** In a basic e-prescribing system, providers use computers to enter prescriptions. In addition, e-prescribing may include: electronic access to clinical decision support information, including clinical guidelines and formulary information and integration with an electronic medical record for access to information such as medical conditions, current and prior medications, allergies and laboratory results.

- **Electronic medical record (EMR).** An electronic medical record provides for electronic entry and storage of patients' medical record data. Depending on the local information technology infrastructure, EMRs may also allow for electronic data transmission and data sharing. More complex EMRs can integrate computerized provider order entry (CPOE) and e-prescribing functions.

- **Inpatient computerized provider order entry (CPOE).** CPOE refers to a computer-based system of ordering diagnostic and treatment services, including laboratory, radiology and medications. A basic CPOE system promotes legible and complete order entry and can provide basic clinical decision support such as suggestions for drug doses and frequencies. More advanced CPOE systems can integrate with an EMR for access to a patient's medical history.

- **Health information exchanges (including regional health information organizations – RHIOs).** These exchanges, such as the Indiana Health Information Exchange, allow participating providers to exchange clinical data electronically. The capacity of health information exchanges varies. Some initiatives provide electronic access only to lab or radiology results, while others offer access to shared, fully integrated medical records.

- **Benchmarking.** Contractors can pool data from multiple providers and "benchmark" or compare metrics related to outcomes, utilization of services and populations. Practice pattern analysis, with appropriate risk adjustment, can help to identify differences in treatment of patients and best practices. Information can be shared with Contractors and providers to help them identify opportunities for improvement, or can be linked to pay for performance initiatives.

- **Telemedicine.** Telemedicine allows provider-to-provider and provider-to-member live interactions, and is especially useful in situations where members do not have easy access to a provider, such as for members in rural areas. Providers also use telemedicine to consult with each other and share their expertise for the benefit of treating complex patients in Hoosier Healthwise and HIP. Contractors are encouraged to develop reimbursement mechanisms to encourage appropriate use of telemedicine.

To ensure interoperability among providers including laboratory, pharmacy, radiology, inpatient hospital/surgery center, outpatient clinical care, home health, public health and others,

organizations at the national level, including the Health IT Standards Panel and the Certification Commission for Health IT, are working to develop standards related to IT architecture, messaging, coding, and privacy/security and a certification process for technologies. The Contractor is encouraged to use these standards in developing their electronic data sharing initiatives, if any.

Currently, resources and infrastructure for HIT vary widely throughout Indiana. There are multiple strategies and tactics that Contractors can adopt to participate directly and to incent providers to participate in HIT. Some examples include:

- Contract or affiliate with existing health information exchanges and information networks
- Develop coalitions with other health care providers to develop health information exchanges and information networks
- Develop proposals for health information exchanges and information networks, and apply for grants to support those proposals
- Require providers to participate in one of Indiana's established health data exchanges or information networks, in regions where those networks are currently established
- Require high-volume prescribers to use some level of e-prescribing, in regions where an infrastructure to support e-prescribing exists
- Require high-volume providers to use EMRs
- Identify providers that are and are not currently participating in information networks or using EMRs, e-prescribing, CPOE or other HIT in order to focus incentives
- Offer incentives to providers for adopting HIT, such as:
    - Provide free or subsidized handheld devices to physicians for electronic prescribing
    - Provide financial or non-financial incentives to providers who adopt EMRs or electronic prescribing

10.0 Performance Reporting and Incentives

The State places great emphasis on the delivery of quality health care to Hoosier Healthwise and HIP members. Performance monitoring and data analysis are critical components in assessing how well the Contractor is maintaining and improving the quality of care delivered in the Hoosier Healthwise and HIP programs. The State uses various performance targets, industry standards, national benchmarks and program-specific standards in monitoring the Contractor's performance and clinical outcomes. **The Contractor must submit performance data specific to the Hoosier Healthwise and HIP programs unless otherwise specified by OMPP.** The State reserves the right to publish the Hoosier Healthwise and HIP program's performance and/or recognize the Contractor when it exceeds performance indicators.

RFS #10-40
ATTACHMENT D
CONTRACTOR SCOPE OF WORK

The Contractor must comply with all reporting requirements and must submit the requested data completely and accurately within the requested timeframes and in the formats identified by OMPP. The State reserves the right to require the Contractor to work with and submit data to third-party data warehouses or analytic vendors. The Contractor must have policies, procedures and mechanisms in place to ensure that the financial and non-financial performance data submitted to OMPP is accurate. The Contractor must submit its performance data and reports under the signatures of either its Financial Officer or Executive Officer (e.g., President, Chief Executive Office, Executive Director), certifying the accuracy, truthfulness and completeness of the Contractor's data. The Contractor Reporting Manual details the reporting requirements that are highlighted below. The 2011 Contractor Reporting Manual shall be provided following the Contract award date and will include changes from the current Hoosier Healthwise and HIP Reporting Manuals. As an example only, the current Hoosier Healthwise Reporting Manual is included in the Bidder's Library. The current HIP Reporting Manual is in the process of being updated and will be available following the RFS release.

OMPP reserves the right to audit the Contractor's self-reported data and change reporting requirements at any time with reasonable notice. OMPP may require corrective actions and will assess liquidated damages, as specified in Attachment B to the Contract, for Contractor non-compliance with these and other subsequent reporting requirements and performance standards. OMPP may change the frequency of reports and may require additional reports. OMPP shall provide at least thirty (30) calendar days notice to the Contractor before changing reporting requirements. OMPP may request ad hoc reports at any time. See the Contractor Reporting Manual, which shall be provided following the Contract award date, for detail regarding OMPP's reporting requirements and the full list of required reports.

10.1 Financial Reports

Financial Reports assist OMPP in monitoring the Contractor's financial trends to assess its stability and continued ability to offer health care services to its members. If the Contractor does not meet the financial reporting requirements, OMPP will notify the Contractor of the non-compliance and designate a period of time, not less than ten (10) calendar days, during which the Contractor must provide a written response to the notification. Contractors must meet IDOI licensure and financial requirements.

- Financial Stability Indicators – includes Third Party Liability Collections (Quarterly)
- IDOI Filing (Quarterly, Annually)
- Reimbursement for FQHC and RHC Services (Annually)
- Physician Incentive Plan Disclosure (Annually)
- Insurance Premium Notice (Annually)
- Stop Loss (Semi-annually)

10.2 Member Service Reports

Member Service Reports identify the methods the Contractor uses to communicate to members about preventive health care and program services and monitor member satisfaction.

- Member Helpline Performance Report (Quarterly)
- Member Grievances Report (Quarterly)
- Member Appeals Report (Quarterly)
- Member Grievances Log (Ad Hoc – must be available during OMPP onsite visits)

- Member Appeals Log (Ad Hoc – must be available during OMPP onsite visits)
- FSSA Hearing and Appeals (Quarterly)
- Summary of Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey (Annually)
- Member Website Utilization Report, including EOB and quality information hits (Contractor must have the capability to track this data and report it to OMPP upon request)
- POWER Account Contribution and CHIP Premium Collection Report (Quarterly)
- Redetermination Outreach Report (Contractor must have the capability to track data demonstrating all outreach activities related to redetermination and report this information to OMPP upon request)

OMPP reserves the right to require more frequent Member Service reporting at the beginning of the Contract and as necessary to ensure satisfactory levels of member service.

10.3 Network Development Reports

Network Development Reports assist OMPP in monitoring the Contractor's network composition by specialty and geoaccess ratios in order to assess member access and network capacity. The Contractor must identify current enrollment, gaps in network services and the corrective actions that the Contractor is taking to resolve any potential problems relating to network access and capacity. The Network Development Reports include but are not limited to:

- Network Geographic Access Assessment: PMPs, Specialists and Behavioral Health Providers (Annually and when significant changes occur)
- Twenty four (24)-Hour Availability Audit (Annually)
- Subcontractor Compliance Summary Report (Annually)

OMPP will require more frequent Network Geographic Access Assessment reporting at the beginning of the Contract, until the Contractor demonstrates that the network access standards have been met.

10.4 Provider Service Reports

Provider Service Reports assist OMPP in monitoring the methods the Contractor uses to communicate to providers about clinical, technical and quality management and improvement issues relating to the program.

- Provider Helpline Performance Report (Quarterly)
- Formal Provider Claims Disputes (Quarterly)
- Binding Arbitration (Ad Hoc)

10.5 Quality Management Reports

Quality Management Reports document the methods and processes the Contractor uses to identify program and clinical improvements that enhance the appropriate access, level of care, quality and utilization of program services by its members and providers. These reports assist OMPP in monitoring the Contractor's quality management and improvement activities.

- Quality Management and Improvement Program Work Plan (Annually, with Quarterly updates)

- Quality Management Committee Meeting Minutes (Quarterly)
- HEDIS Data Submission Tool (Annually)
- HEDIS Auditor Report (Annually)
- Disease Management Report (Quarterly)
- Case/Care Management Reports (Quarterly)
- New Member Health Screenings Report (Quarterly)

10.6 Utilization Reports

Utilization Reports assist OMPP in monitoring the Contractor's utilization trends to assess its stability and continued ability to offer health care services to its members.

- Program Integrity Plan (Annually, with quarterly progress reports)
- Prior Authorization Report (Quarterly)
- Capitation Rate Calculation Sheet (Quarterly)
- Maternity Capitation Rate Calculation Sheet (Quarterly) – For Hoosier Healthwise only

10.7 Claims Reports

These reports assist OMPP in monitoring the Contractor's claims processing activities to ensure appropriate member access to services and payments to providers. The Contractor must submit claims processing and adjudication data. The Contractor must also identify specific cases and trends to prevent and respond to any potential problems relating to timely and appropriate claims processing. The Contractor must submit the following data and reports:

- Adjudicated Claims Summary – includes Claims Aging Summary and Claims Lag Report (Quarterly)
- Top 10 Claims Denial Reasons (Ad Hoc)
- Claims Processing Summary – includes Outstanding Claims Inventory Summary and Interest Paid on Claims (Quarterly)

10.8 HIP Reports

Due to HIP's unique program design, the Contractor shall also be required to provide the following reports for its HIP line of business:

- POWER Account Summary (Annually)
- Benefit Design Summary (Annually)
- ESP Referrals Report (Monthly)
- Buy-In Participation Report (Quarterly)
- Preventive Care Report (Quarterly)
- Annual and Lifetime Benefit Reports (Monthly)
- Pregnancy Identification Report (Monthly)

The Contractor must be prepared to break out HIP data, including but not limited to enrollment data, non-payment of POWER Account contribution data and other POWER Account data, according to the following FPL categories:

- 0-22% FPL
- 22-50% FPL
- 50-100% FPL
- 100-150% FPL
- 150-200% FPL

10.9 CMS Reporting

The Contractor shall be required to submit data requested by the Centers for Medicare and Medicaid Services (CMS). For example, OMPP has conference calls with CMS on a monthly basis. In preparation for these calls, OMPP will ask the Contractor for data requested by CMS. The Contractor shall submit this data in the timeframe specified by OMPP. The following are examples of data requested by CMS for the HIP program in 2009:

Enrollment & Implementation Update	
	Denials for failure to make initial POWER Account contributions
	Terminations for failure to make subsequent POWER Account contributions
	HIP members who have become pregnant
	HIP members who have been found eligible under Medicaid ABD
	Members Within $100,000 of the Annual/Lifetime Benefit Limits

ER Copayments				
HIP Population	**Co-Payment Amount**	**Number of Plan A Members**	**Number of Plan B Members**	**Total HIP Members**
Caretakers	$0 per visit			
Caretakers With Incomes Above AFDC Income Limit through 100% FPL	$3 per visit			
Caretakers Above 100 % through 150% FPL	$6 per visit			
Caretakers Above 150 % through 200% FPL	Lower of 20% of services cost provided during visit, or $25			
Non-Caretakers	$25 per visit			

Other	
	POWER Accounts
	Employer contributions
	POWER Account roll over
	Member incentives offered by MCOs

10.10 Other Reporting

OMPP reserves the right to require additional reports to address program-related issues that are not anticipated at the time of RFS release but are determined by OMPP to be necessary for program monitoring.

11.0 Failure to Perform/Non-compliance Remedies

11.1 Non-compliance Remedies

It is the State's primary goal to ensure that the Contractor is delivering quality care to members. To assess attainment of this goal, the State monitors certain quality and performance standards, and holds the Contractor accountable for being in compliance with Contract terms. OMPP accomplishes this by working collaboratively with the Contractor to maintain and improve programs, and not to impair health plan stability.

In the event that the Contractor fails to meet performance requirements or reporting standards set forth in the RFS, the Contract or the Contractor Reporting Manual, the State will provide the Contractor with a written notice of non-compliance and may require any of the corrective actions or remedies discussed in Attachment B to the Contract. The State will provide written notice of non-compliance to the Contractor within sixty (60) calendar days of the State's discovery of such non-compliance.

If OMPP elects not to exercise a corrective action clause contained anywhere in the RFS or Contract in a particular instance, this decision must not be construed as a waiver of the State's right to pursue future assessment of that performance requirement and associated damages, including damages that, under the terms of the RFS or the Contract, may be retroactively assessed.

11.2 Evidence of Financial Responsibility

The Contractor must provide a performance bond of standard commercial scope issued by a surety company registered with the IDOI or other evidence of financial responsibility to guarantee performance by the Contractor of its obligations under the Contract. A separate performance bond or other evidence of financial responsibility in the amount of $1,000,000 is required for the Contractor's Hoosier Healthwise and HIP lines of business.

The State reserves the right to increase the financial responsibility requirements set forth in this section if enrollment levels indicate the need to do so. In the event of a default by the Contractor, the State must, in addition to any other remedies it may have under the Contract, obtain payment under the performance bond or other arrangement for the purposes of the following:

- Reimbursing the State for any expenses incurred by reason of a breach of the Contractor's obligations under the Contract, including, but not limited to, expenses incurred after termination of the Contract for reasons other than the convenience of the State.

- Reimbursing the State for costs incurred in procuring replacement services.

12.0 Termination Provisions

12.1 Contract Terminations

OMPP reserves the right to terminate the Contract, in whole or in part, due to the failure of the Contractor to comply with any term or condition of the Contract, or failure to take corrective action as required by OMPP to comply with the terms of the Contract. The Contract between the parties may be terminated on the following basis listed below:

- By mutual written agreement of the State and Contractor.

- By the Contractor, subject to the remedies listed in the RFS.

- By the State, in whole or in part, whenever the State determines that the Contractor has failed to satisfactorily perform its contracted duties and responsibilities and is unable to cure such failure within sixty (60) calendar days after receipt of a notice specifying those conditions.

- By the State, in whole or in part, whenever, for any reason, the State determines that such termination is in the best interest of the State, with at least thirty (30) calendar days prior notice to the Contractor.

- By the State, in whole or in part, whenever funding from state, federal or other sources are withdrawn, reduced or limited, with sufficient prior notice to the Contractor.

- By the State, in whole or in part, whenever the State determines that the instability of the Contractor's financial condition threatens delivery of Medicaid services and continued performance of Contractor responsibilities.

The State will provide the Contractor with a hearing prior to contract termination in accordance with 42 CFR 438.708.

12.1.1 Termination by the State

The State may terminate the Contract, in whole or in part, whenever the State determines that the Contractor or a subcontractor has failed to satisfactorily perform its contracted duties and responsibilities and is unable to cure such failure within sixty (60) calendar days, or such other reasonable period of time as specified in writing by the State, taking into consideration the gravity and nature of the default. Such termination must be referred to herein as "Termination for Default."

Upon determination by the State that the Contractor has failed to satisfactorily perform its contracted duties and responsibilities, the Contractor must be notified in writing, by either certified or registered mail, of the failure and of the time period which has been established to

cure such failure. If the Contractor is unable to cure the failure within the specified time period, the State will notify the Contractor that the Contract, in full or in part, has been terminated for default.

If, after notice of termination for default, it is determined by the State or by a court of law that the Contractor was not in default or that the Contractor's failure to perform or make progress in performance was due to causes beyond the control of, and without error or negligence on the part of, the Contractor or any of its subcontractors, the notice of termination must be deemed to have been issued as a termination for the convenience of the State, and the rights and obligations of the parties must be governed accordingly.

In the event of termination for default, in full or in part, as provided under this clause, the State may procure, upon such terms and in such manner as is deemed appropriate by the State, supplies or services similar to those terminated, and the Contractor shall be liable for any costs for such similar supplies and services and all other damages allowed by law. In addition, the Contractor shall be liable to the State for costs incurred to procure such similar supplies or services as are needed to continue operations.

In the event of a termination for default prior to the start of operations, any claim the Contractor may assert must be governed by the procedures defined in the RFS.

In the event of a termination for default during ongoing operations, the Contractor will be paid for any outstanding capitation payments due, less any assessed damages.

The rights and remedies of the State provided in this clause are not exclusive and are in addition to any other rights and remedies provided by law or under the Contract.

12.1.2 Termination for Financial Instability

OMPP may terminate the Contract immediately upon the occurrence of any of the following events:

- The Contractor becomes financially unstable to the point of threatening the ability of the State to obtain the services provided for under the Contract
- The Contractor ceases to conduct business in normal course
- The Contractor makes a general assignment for the benefit of creditors
- The Contractor suffers or permits the appointment of a receiver for its business or assets

The State may, at its option, immediately terminate the Contract effective at the close of business on the date specified. In the event the State elects to terminate the Contract under this provision, the Contractor must be notified in writing, by either certified or registered mail, specifying the date of termination. In the event of the filing of a petition in bankruptcy by or against a principal subcontractor, the Contractor must immediately so advise the Contract Administrator as specified in the Contract between the State and the Contractor. The Contractor must ensure that all tasks related to the subcontract are performed in accordance with the terms of the Contract.

12.1.3 Termination for Failure to Disclose Records

The State may terminate the Contract, in whole or in part, whenever the State determines that the Contractor has failed to make available to any authorized representative of the State, any administrative, financial and medical records relating to the delivery of services for which state Medicaid and/or CHIP program dollars have been expended.

In the event that the State terminates the Contract pursuant to this provision, the Contractor must be notified in writing, either by certified or registered mail, either sixty (60) calendar days prior to or such other reasonable period of time prior to the effective date, of the basis and extent of the termination. Termination must be effective as of the close of business on the date specified in the notice.

12.1.4 Termination by the Contractor

The Contractor must give advance written notice of termination, or intent not to renew, to the State a minimum of one hundred and eighty (180) calendar days prior to termination. The effective date of the termination must be no earlier than the last day of the month in which the one hundred and eightieth (180^{th}) day falls. Termination of the Contract by the Contractor is subject to damages listed in Section 12.4.

12.2 Termination Procedures

When termination is anticipated, OMPP will deliver to the Contractor a Notice of Termination by certified or registered mail specifying the nature of the termination and the date upon which such termination becomes effective. Within ten (10) calendar days of receipt of the Notice of Termination, the Contractor must develop and submit a Transition Plan for OMPP's approval that addresses:

- Stopping work under the Contract, on the date and to the extent specified in the Notice of Termination.
- Placing no further orders or subcontracts for materials, services or facilities.
- Notifying all of the Contractor's members regarding the date of termination and the process by which members will continue to receive medical care. For its HIP members, the Contractor must also explain how they will have access to POWER Account funds and have use of their POWER Account debit cards. OMPP must approve all member notification materials in advance of distribution.
- Terminating all orders and subcontracts, to the extent that they relate to the performance of work terminated by the Notice of Termination.
- Assigning activities to the State, its designee or successor contractor, in the manner and to the extent that they relate to the performance of work terminated by the Notice of Termination.
- Assigning to the State, its designee or successor MCO, in the manner and to the extent directed, all of the rights, titles and interests of the Contractor under the orders or subcontracts so terminated.

- With the approval of the State, settling outstanding liabilities and all claims arising out of such termination of orders and subcontracts.

- With the approval of the State, establishing a plan for transferring member POWER Account funds and related information to the State, its designee or the successor MCO.

- Within ten (10) business days from the effective date of the termination, transferring title to the State of Indiana (to the extent that title has not already been transferred) and deliver, in the manner and to the extent directed, all data, other information and documentation, in any form that relates to the work terminated by the Notice of Termination.

- Completing the performance of such part of work that has not been specified for termination by the Notice of Termination.

- Taking such action as may be necessary, or as the State may direct, for the protection and preservation of the property related to the Contract that is in the possession of the Contractor and in which the State has or may acquire an interest.

- Providing for all the Contractor's responsibilities set forth in Section 12.3 below.

The requirements listed above are illustrative only and do not limit or restrict the State's ability to require the Contractor to address additional issues in its Transition Plan.

The State shall withhold the Contractor's final capitation payment until the Contractor has 1) received OMPP approval of its Transition Plan and 2) completed the activities set forth in its Transition Plan, as well as any additional activities requested by OMPP, to the satisfaction of OMPP. Satisfactory completion of the Contractor's transition responsibilities pursuant to the OMPP-approved Transition Plan shall be made at the sole discretion of OMPP.

12.3 Contractor Responsibilities Upon Termination or Expiration of the Contract

Termination or expiration of the Contract does not discharge the obligations of the Contractor with respect to services or items furnished prior to termination or expiration of the Contract, including retention of records and verification of overpayments or underpayments. Termination or expiration of the Contract does not discharge the State's payment obligations to the Contractor or the Contractor's payment obligations to its subcontractors and providers. Upon termination or expiration of the Contract, the Contractor must:

- Assist the State in taking the necessary steps to ensure a smooth transition of services after expiration or termination of the Contract.

- Provide a written Transition Plan for the State's approval. In the event of Contract termination, the Transition Plan shall be due within ten (10) calendar days of receiving Notice of Termination from the State. In the event of Contract expiration, the Transition Plan shall be due at least one hundred and eighty (180) calendar days prior to expiration of the Contract. The Contractor will revise and resubmit the Transition Plan to the State on a regular basis, the frequency of which will be determined by the State.

- Appoint a liaison for post-transition concerns

- Provide for sufficient claims payment staff, member services staff, POWER Account staff and provider services staff to ensure a smooth transition.

- Provide the State with all information requested by the State in the format and within the timeframes set forth by the State, which shall be no later than thirty (30) calendar days of the request, including for HIP members up-to-date data about POWER Account balances, annual and lifetime benefit totals and member utilization of recommended preventive services.

- Assist the State and/or its subcontractors in FQHC/RHC settlement process for settlement periods prior to the day of termination or expiration of the Contract. Requested assistance may include but is not limited to data support for questions regarding FQHC/RHC claims data and reports and the submission of claims data files to the State and/or its vendors.

- Be financially responsible for all claims with dates of service through the day of termination or expiration of the Contract, including those submitted within established time limits after the day of termination or expiration of the Contract.

- Be responsible for submitting encounter data to the State for all claims incurred prior to the contract expiration date according to established timelines and procedures and for a period of at least fifteen (15) months after termination or expiration of the Contract.

- Be responsible for submitting all performance data with a due date following the termination or expiration of the Contract, but covering a reporting period prior to termination or expiration of the Contract, including but not limited to CAHPS, HEDIS, Reimbursement for FQHC and RHC Services and the Capitation Rate Calculation Sheet.

- Be responsible for resolving member grievances and appeals with respect to claims with dates of service prior to the day of contract expiration, including grievances and appeals filed on or after the day of Contract termination or expiration but with dates of service prior to the day of Contract termination or expiration.

- Be financially responsible for inpatient services for patients hospitalized on or before the day of Contract termination or expiration through the date of discharge, including the DRG payment and any outlier payments.

- Be financially responsible for services rendered through the day of termination or expiration of the Contract, for which payment is denied by the Contractor and subsequently approved upon appeal by the provider.

- Be financially responsible for member appeals of adverse decisions rendered by the Contractor concerning treatment of services requested prior to termination or expiration of the Contract which are subsequently upheld on behalf of the member after an appeal proceeding or after a FSSA Fair Hearing.

- Arrange for the orderly transfer of patient care and patient records to those providers who will assume care for the member. For those members in a course of treatment for which a change of providers could be harmful, the Contractor must continue to provide services until that treatment is concluded or appropriate transfer of care can be arranged. The Contractor shall transfer all applicable clinical information on file, including but not limited to approved

and outstanding prior authorization requests and a list of members in case or care management, to the State and/or the successor MCO at least fourteen (14) calendar days prior to the day of termination or expiration of the Contract. A final file shall be provided within five (5) business days of the termination or expiration of the Contract.

- Notify all members about the Contract termination and the process by which members will continue to make POWER Account contribution and Hoosier Healthwise Package C (CHIP) premium payment, and receive medical care, at least sixty (60) calendar days in advance of the effective date of termination or Contract expiration. For its HIP members, the Contractor must also explain how they will have access to POWER Account funds and have use of their POWER Account debit cards. The Contractor will be responsible for all expenses associated with member notification. OMPP must approve all member notification materials in advance of distribution.

- Notify all providers about the Contract termination and the process by which members will continue to receive medical care, at least sixty (60) calendar days in advance of the effective day of termination or expiration of the Contract. The Contractor will be responsible for all expenses associated with provider notification. OMPP must approve all provider notification materials in advance of distribution.

- Report any capitation or other overpayments made by the State to the Contractor within thirty (30) calendar days of discovery and cooperate with investigations by the State or its subcontractors into possible overpayments made during the contract term. The Contractor shall return any capitation or other overpayments, including those discovered after contract expiration, to the State within fourteen (14) calendar days of reporting the overpayment to the State.

- Coordinate the continuation of care for members who are undergoing treatment for an acute condition.

- Be responsible to submit the HEDIS Auditor Report listed in Section 10, in accordance with the applicable due date, and to participate in the External Quality Review, as required by 42 CFR 438, Subpart E, for the final year of the Contract.

- Comply with any additional items the State required the Contractor to address in its Transition Plan

The State reserves the right to withhold some or all retroactive capitation adjustment payments due and owing to the Contract in the event the Contractor fails to comply with the responsibilities set forth in this section, including its responsibilities related to data submission and support.

12.4 Damages

The Contractor acknowledges that any failure or unreasonable delay on its part in affecting a smooth transition will cause irreparable injury to the State, which may not be adequately compensable in damages. The Contractor acknowledges that the State has incurred substantial expenses in connection with the preparation and entry into the Contract, including expenses relating to training staff, data collection and processing, actuarial determination of capitation rates, and ongoing changes to the State's and its fiscal agent's management information systems.

The Contractor further acknowledges and agrees that in the event the Contract is terminated prior to the end of the initial term or any renewal term, due to the actions of the Contractor or due to the Contractor's failure to fully comply with the terms and conditions of the Contract, the State will incur substantial additional expense in processing the disenrollment of all members and the related MIS changes, in effecting staffing changes, in procuring alternative health care arrangements for members, and in other areas unknown to the State at this time. The Contractor accordingly agrees that the State may, in such event, seek and obtain injunctive relief, as well as actual damages.

The remedies available to the State under this Agreement include but are not limited to:

- Obtaining payment under the performance bond or other arrangement set forth in Section 11.2

- Assessing actual damages measured by the cost to the State to transition members to other providers and/or another Contractor. This includes, but is not limited to, payments the State may make to other contractors to perform work related to the transition.

- Liquidated damages equal to one percent of the maximum monthly capitation payment the Contractor has received under the Contract multiplied by the number of months of the Contract term remaining after the effective date of termination

Payment of the performance bond or other arrangement established under Section 11.2 is due within ten (10) calendar days of the date of termination. Payment of liquidated damages is due within thirty (30) calendar days from the date of termination. Payment of actual damages is due within ten (10) calendar days of the Contractor's receipt of the State's demand for payment.

12.5 Assignment of Terminating Contractor's Membership and Responsibilities

If the Contract is terminated for any reason, the State may assign the Contractor's membership and responsibilities to one or more other MCOs who also provide services to the Hoosier Healthwise and HIP populations, subject to consent by the MCO that would gain the member enrollment.

In the event that OMPP assigns members or responsibility to another MCO, during the final quarter of the Contract, the Contractor will work cooperatively with, and supply program information to, any successor MCOs. Both the program information and the working relationship among the Contractor and successor MCOs will be defined by the State.

12.6 Refunds of Advanced Payments

The Contractor must, within thirty (30) calendar days of receipt, return any funds advanced for coverage of members for periods after the date of termination of the Contract.

12.7 Termination Claims

If the Contract is terminated under this section, the Contractor must be entitled to be paid a prorated capitation amount, determined by the State based on available information, for the month in which notice of termination was received for the service days prior to the effective date of termination. The Contractor will have the right of appeal, as stated under the subsection on

Disputes in the Contract, of any such determination. The Contractor will not be entitled to payment of any services performed after the effective date of termination.